VA CONSTRUCTION ACTIVITIES REORGANIZATION—DEPARTMENT OF MEDICINE AND SURGERY

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VA CONSTRUCTION ACTIVITIES REORGANIZATION—DEPARTMENT OF MEDICINE AND SURGERY

THURSDAY, AUGUST 7, 1986

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Montgomery, Evans, Penny, Rowland of Georgia, Kanjorski, Daschle, Hammerschmidt, McEwen, Smith of New Jersey, Bilirakis, Molinari, and Rowland of Connecticut.

OPENING STATEMENT OF CHAIRMAN BOB EDGAR

Mr. EDGAR. The hearing will come to order.

I would like to ask unanimous consent that the full text of my opening statement be made a part of the record. Without objection, so ordered.

Mr. EDGAR. I wish to welcome the Administrator of Veterans' Affairs, Thomas Turnage, to our committee today. I am certain I can speak for my colleagues when I say we are pleased he chose this hearing for his first appearance before the House Committee on Veterans' Affairs and we look forward to his testimony today.

I know there is a strong consensus between the chairman of the full committee, Sonny Montgomery, the ranking Republican, John Paul Hammerschmidt, and myself that this hearing is both timely and necessary. This committee, over the years, has spent considerable time and energy attempting to grapple with and improve the VA's construction program. There is no doubt we face a real dilemma in this regard. As budgets shrink, the demand on the VA is ballooning at the same speed as its medical facilities are aging and needing renovation and replacement. There is no doubt that we are forced to do more with less these days and still maintain the highest quality medical care possible for our Nation's veterans.

We supported the idea of a contract which was let to Booz-Allen & Hamilton for an outside consultant to come in to the VA to study the construction process, write a report, and make recommendations on how best to improve that process. However, we are concerned over the two different responses on proposals for con-

struction reform which were based on that report over the past 2 years.

The previous Administrator planned a reorganization based on the report that would have put all of the construction programs into the Department of Medicine and Surgery. The present Administrator has a reorganization plan based on the report that pulls all of the construction activities out of the Department of Medicine and Surgery and puts them into the Office of Facilities.

We are concerned over the impact that this may have, or any of these proposed changes would have, on the delivery of health care for our Nation's veterans. We are particularly concerned over the impact this most recent proposal will have on the ability of the Chief Medical Director and the Department of Medicine and Surgery to influence and facilitate the construction process.

Our main objective in holding these hearings is to receive information to ensure that any so-called construction reform or construction reorganization is a reform or a re-organization that improves the delivery of health care services for our Nation's veterans. For these reasons, I believe this hearing deserves special attention, and I appreciate the Administrator and other witnesses being with us today.

I yield to my colleague, John Paul Hammerschmidt.

[Prepared statement of Hon. Bob Edgar appears at p. 45.]

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman. I want to join you in welcoming all of our witnesses here today.

I regret that before too long I'm going to have to leave because we have a markup on the airport transfer bill in the Aviation Subcommittee, but I particularly want to welcome the new Administrator of Veterans' Affairs in his first appearance as Administrator.

General Turnage, we wish you well as you meet the many challenges of heading the larest independent agency in the Government. I know from your past record that you have done such a fine job as Director of the Selective Service that you will do well here, also.

Hearings on this subject had been scheduled for earlier this year. It was delayed at the request of the Veterans' Administration in order to give the new Administrator an opportunity to consider the options available for the improvement of the VA's construction program. The request was reasonable and the committee agreed to it.

Now a new decision has been made to reorganize construction. The time is appropriate for a hearing so that the committee may be informed about the new system. Thus, Mr. Chairman, I commend you for calling this hearing.

There is remarkable agreement between a private consultant, the GAO, and the VA on what needs improvement in the VA's construction program, which is one of major portions, consuming hundreds of millions of tax dollars yearly. Several recommendations on new organizational structures for the construction program were evaluated at the VA. We know that the Department of Medicine

and Surgery has expressed considerable concern about the Administrator's decision on this matter. That decision parallels in some ways the decision reached by the former Administrator. It deviates from it in other significant respects.

Any discussion as to these differences, and the reasons for the decision reached, would be welcomed in this hearing this morning. It may be that there is no single, clear right choice. It may be a matter of style and approach. In any event, the proof is in the pudding, and after the new system has been operating for 6 months or so and has had a fair chance, we should check on it to see how it's doing.

In my view, improvements in the VA's construction process have the potential to save many millions of dollars which could go for other critical veterans' needs. Almost everyone agrees that 8 years on the average is far too long a time for designing and building a new medical center. Hopefully, this time factor can be reduced considerably.

So, Mr. Chairman, the VA has launched a new construction organization. I look forward to learning more about it.

Thank you very much, Mr. Chairman.

Mr. EDGAR. Thank you.

Are there any other opening statements? Mr. Bilirakis.

Mr. BILIRAKIS. Thank you.

Mr. Chairman, it is a privilege to join you and our ranking member, Mr. Hammerschmidt, in welcoming the 13th Administrator of the Veterans' Administration to our committee today for what I hope will be the first of many exchanges with us.

General Turnage, your long and distinguished military career and your continuing service to this Nation as Director of the Selective Service and now the VA speaks well of your commitment to caring for those who have borne the battle, our American veterans.

I want to get parochial for a moment, General, if you will forgive me, and thank you for the approval you gave earlier this week for expanding the veterans' outpatient clinic in Pasco County, Florida, in my congressional district. I can tell you, it means an awful lot to the veterans in the area and to me, and I wanted to let you know that personally.

However, the history of this particular clinic, sir, is also a good case in point for today's hearing, as we examine what is wrong with the VA's present facility planning process and search for ways to improve it. When I came to Congress in 1983, getting approval to open an outpatient clinic for veterans in the Pasco County area was one of my chief goals because the need for such a facility was just so great and so obvious, at least to the veterans and to me.

Yet we had great difficulty convincing local VA officials of that need. The VA's own internal mechanisms for assessing needs, including the MEDIPP process, failed to recognize the need in this area. It was up to my office and the veterans themselves to put together statistics and other supporting information.

After a long and often frustrating schedule, I am pleased to say that a clinic was finally opened in September of 1985. When it became obvious that this facility was going to become a reality, the MEDIPP process suddenly resulted in identifying this need. And

now, 4 years after we began our efforts, 4 years after we were told that there was no need, that same MEDIPP process clearly demonstrates that the clinic needs to be expanded from a capacity of 6,800 visits per year to a capacity of 33,500 visits. We knew it all along, General. Why didn't the VA is the question, of course, that I have always had.

I just make that point as one example of the problems we have encountered in this whole process of identifying facility needs and prioritizing them. I look forward to hearing from you, General Turnage, as well as our other witnesses, on proposed solutions to these problems.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you very much.

Are there any other opening statements? If not, we will move now to our first witness. Mr. Turnage, would you come forward to the witness table. We welcome you here today and we invite your testimony, and hope that you will introduce the staff with you today.

STATEMENT OF HON. THOMAS K. TURNAGE, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION; ACCOMPANIED BY JOHN GRONVALL, M.D., DEPUTY CHIEF MEDICAL DIRECTOR; SUSAN M. LIVINGSTONE, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; GERALD NEUMANN, DIRECTOR, OFFICE OF CONSTRUCTION; AND JAMES DE WIRE, CHIEF OF STAFF

Mr. TURNAGE. Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to present testimony and respond to questions concerning the recently announced organizational and procedural improvements in the VA's capital facilities program.

With me today, on my left, is Mr. James DeWire, who is the Chief of Staff of the Veterans' Administration; Mrs. Susan Livingstone, who is Associate Deputy Administrator for Logistics; Dr. John Gronvall, who is the Deputy Chief Medical Director; and Mr. Gerald E. Neumann, who is the Director of the Office of Construction.

I ask that my prepared statement be submitted for the record, along with my July 25, 1986, decision memorandum and related series of questions and answers which further explain the realignment of the VA's capital facilities functions. Today I would like to briefly summarize the information provided in my prepared statement.

As you know, the VA's capital facilities program is a very significant program activity for our agency. The VA operates the second largest construction program in the Federal Government and the largest medical facility construction program in the Nation. Clearly, the VA's capital facilities and real property holdings are critical to fulfilling the mission of this agency, to provide quality service on a timely basis to this Nation's veterans. To the extent we can improve our management of these program activities, we must constantly strive to do so.

Such an effort was undertaken in March 1984, when the VA contracted with Booz-Allen and Hamilton and RTKL Associates to conduct a comprehensive study of the agency's organization and procedures for constructing health care facilities. The final report, issued in April 1985, contains two primary findings. The first and most important finding is that the VA's current health care facility policies and procedures, principally in the area of program and project planning, need to be improved. Second, the VA's integration and coordination of its health care facilities construction program are hindered by the current fragmentation of responsibilities between the Department of Medicine and Surgery and the Office of Construction to the degree that there is no single accountable or responsible entity below the level of the Administrator for the agency's capital facilities program.

Now, in October 1985, the former Administrator of Veterans' Affairs announced his intention to transfer the Office of Construction as a unit to the Department of Medicine and Surgery, based, in part, on the findings and recommendations of the Booz-Allen, RTKL study. On March 24, 1986, I was confirmed as the new Administrator of Veterans' Affairs, and by letter of early April to the House Committee on Veterans' Affairs, asked that scheduled hearings on the proposed reorganization be postponed in order to permit my review of the proposed organizational change. I completed that review on July 13. A draft copy of my findings, conclusions and decision also was provided to this committee. On July 17, my Chief of Staff, Jim DeWire, then briefed committee staff on the draft decision memorandum which was subsequently issued in final form on July 25. A second briefing was held on July 25 to provide further information to committee staff on the decision which was made.

My July 25, 1986, decision memorandum explains the rationale for retaining the agency's capital facilities program in an independent staff office function, through the transfer of 64 of the 73 FEPAC FTEE ceiling from the DM&S to the Office of Construction, along with supporting resources. As the provisions of 38 U.S.C. section 210(b)(2) do not apply to this realignment, the agency's previous legislative proposal to waive the requirements of 38 U.S.C. section 210(b)(2) regarding the former Administrator's proposed reorganization has been withdrawn. On July 31, 1986, the 64 FEPAC FTEE were detailed to the Office of Construction on an interim basis to facilitate this transition.

Effective October 1 of this year, the newly combined FEPAC and Office of Construction offices will be renamed the "Office of Facilities" to better reflect its responsibilities for overall management of an integrated capital facilities program, including real property management, space management, overall facility planning, and project planning, design and construction activities.

The establishment of an integrated capital facilities staff office function in the VA will create a unified system for the agency's capital facilities and real property programs and establish a single focus of management responsibility and accountability. The new Office of Facilities will be charged with effectively and efficiently meeting the facility needs of DM&S, the Department of Veterans Benefits, the Department of Memorial Affairs and the VA staff of-

fices in a manner which reflects the program needs and priorities of these entities, constituting the whole.

One issue which probably has been misunderstood in this realignment pertains to the transfer of FEPAC's central office engineering service to the Office of Facilities. The concern has been expressed that this move will in some manner hinder the ability of medical centers to manage their day-to-day operational requirements. I wish to emphasize now that the realignment will in no way undermine or hinder the ability of our medical center directors to perform their job. Indeed, with the enhanced participation of the medical centers in construction planning, the streamlining of the process, and the elimination of Central Office organizational redundancies, we envision the capital facilities support and service to our medical centers will improve measurably. Field engineers, as DM&S employees, will continue to manage recurring maintenance and repair programs and day-to-day operational needs, as they always have. The purpose of transferring the Central Office engineering service staff to the new Office of Facilities is to provide a totally integrated capital facilities program which includes the major, minor, minor miscellaneous, and nonrecurring maintenance and repair construction programs, as well as real property programs.

I also wish to emphasize that this realignment in no manner undermines the Chief Medical Director's authorities or ability to fulfill his mission. The Office of Facilities is a service organization whose function and responsibility are to meet the facility needs of DM&S as identified and prioritized by the Chief Medical Director. The Chief Medical Director and other department and staff office heads are fully responsible for program planning and prioritization of needs. The Office of Facilities is charged with meeting those needs in support of the statutory authorities and responsibilities assigned to the Administrator in 38 U.S. Code 5001-5007.

We believe our planned organizational and procedural initiatives will result in measureable improvements in the planning, design, and construction of VA facilities, and we look forward to our first year of implementation.

Mr. Chairman, I would like to thank you for the opportunity to appear here today. My staff and I would be pleased to answer any questions that you or other members may have.

[Prepared statement of Administrator Thomas Turnage, with attachments, appears at p. 55.]

Mr. EDGAR. Thank you, Mr. Turnage. We appreciate your statement. I have just two questions that I would like to raise with you. Then my colleague, Mr. Daschle, will Chair the remainder of the hearing. I know my other colleagues have some detailed questions that they would like to raise with you.

First, I wonder if you would describe the organizational chart in as graphic a way as you can. We had one proposal by the previous Administrator that moved the Office of Construction under the Department of Medicine and Surgery, the medical side. I am still unclear as to what you're suggesting. Are you suggesting that this Office of Facilities is simply under your jurisdiction over in the Administrator's Office? What does the flow chart look like?

Mr. TURNAGE. Even though graphically it may be difficult to describe, I think the change is rather simplistic, in the sense that what Mr. Walters proposed is essentially no great departure from what we are now proposing, with one major exception. In the preceding arrangement, he was going to move the Office of Construction into D&MS and there it would incorporate the FEPAC operation, in effect, making it a single integrated operation at that point under the auspices of the Chief Medical Director.

Essentially, we are doing precisely the same thing from an organizational standpoint, excepting that full office, including the Office of Construction and FEPAC, will remain or reside under the Office of Logistics, which is chaired by Mrs. Livingstone. It will perform the same function. It will have the same capability, except, in effect, it will be a one-stop shopping operation as opposed to going through multiple channels, which I found, based on my many visits to the field, Medical Center Director find difficult and time consuming. In effect, the purposes are the same; where it will end up will change.

Now, it is the lowest common denominator, from my point of view, sir, that will be able to serve the entire agency as opposed to residing one department.

Mr. EDGAR. I understand the answer to my first question, which brings me to my second question and that is: during my few years here in Washington, given the broad scope of activities of the Veterans' Administration, I have discovered that the hospital and health care and medical functions are a major responsibility, taking up a large portion of the Federal budget in terms of $9 or $10 billion of commitment, if you include with the health delivery about a billion dollars worth of construction that we were averaging over the last several years.

Where in this flow chart is the Chief Medical Director, where is the Chief Medical Director's role, and shouldn't the Chief Medical Director, who has the responsibility over quality and quantity of care, play a more dominant role in that than simply having to go through another major department of office in order to get response and responsiveness to the needs of new construction and rehabilitation?

Mr. TURNAGE. Mr. Chairman, according to my understanding of the statute, that responsibility also reposes in the Administrator of Veterans' Affairs. I'm responsible for that, and I obviously can't perform that function in a vacuum. I look to the Chief Medical Director to have the great responsibility for that function.

Mr. EDGAR. But how would the Chief Medical Director now operate?

Mr. TURNAGE. He has no change in his requirements or in his priorities or in his planning process. He is still responsible for the MEDIPP process to determine his priorities, his needs, and his planning requirements, excepting once that is transmitted to the Administrator and, in fact, concurred in at that point, or as changes are approved and any different direction accomplished at that point, then the requirements are passed on to the Office of Construction, through the Logistics Office to accommodate the requirements. His responsibilities remain the same.

You made a point which I think is so cogent here that I would like to emphasize it. He is, and he has, one of the greatest responsibilities, as far as I'm concerned, in the health care field in this Nation. He spends over $9 billion a year doing it, and he has 193,000 people to supervise, and he has 172 hospitals plus a lot of other of the infrastructure to be responsible for. That being the case, from my perspective, why should we also put the burden of construction on him? I think it should be in another part of the organizational structure of the agency and that's where I put it.

Mr. EDGAR. But the problem is that—due to the large scope of the health care delivery system of which a large chunk is construction, maintenance and rehabilitation of facilities—is it not conceivable under your reorganization proposal, as opposed to that of the previous Administrator, that the Chief Medical Director might want to move in one direction and could not because the decision-making authority is vested in the Office of Facilities?

Mr. TURNAGE. Not from my perception, sir. There is no reason, in my judgment, why there should be an adversarial relationship, or at least a different view, or a different philosophy, existing between the goals and objectives and requirements of the Chief Medical Director and the Administrator of Veterans' Affairs. We both have the responsibility for serving the veteran in the health care area.

Mr. EDGAR. If there is no change, then why do you change it? If there is no change in present responsibilities, why are we changing it?

Mr. TURNAGE. We're not changing it in that sense, sir. We're leaving the Office of Construction where it is, in effect. The proposed change was Mr. Walters'. It has never gone to DM&S. I don't propose that it go there. I intend to keep it where it is, but bring the FEPAC operation from DM&S into the Office of Construction so we'll get away from this layering and different channels which so far have been a great frustration to the field and have been some of the difficulties associated with planning and project completion.

Mr. EDGAR. Well, I will yield to my colleagues. I have a great deal of frustration in understanding how this particular change is going to make more efficient and more doable the process of construction.

I hope that my colleagues will also pursue the issue of maintenance, because there is out in the field a great deal of concern about where the day-to-day maintenance function will go. You indicate in your statement that there will be no change in that area, but there is nervousness in the field.

Mr. TURNAGE. May I respond to that, sir?

Mr. EDGAR. Yes.

Mr. TURNAGE. In the 5 months that I have been in this job, I have visited 16 or 17 medical centers. I asked a myriad of questions covering a broad scope of different issues in which I have an interest, so that I can get a better feel for the direction which we should be going.

I don't find that great concern in the field. I find frustration in the field about the fact that the system has so far been cumbersome to the achievement of their objectives. I find that most of the

concern has been expressed here in the Central Office operation, where there may be a more parochial view about it. I find that what we are proposing can add to many efficiencies in the system, and I hope that, in keeping with the earlier statement by Mr. Hammerschmidt, that you, in fact, would in the next few months look at the system and see how it is achieving its objective.

Mr. EDGAR. I yield to my colleague, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Turnage, I am told that almost all the people in the Department of Medicine and Surgery are in favor of the continued presence of the engineering function in DM&S. I am also told that almost all VA medical center directors agree that an engineering presence should stay in the Department.

In your testimony you state that this is an issue that possibly has been misunderstood. You decided to go ahead with this part of your proposal in spite of the widespread apprehension about it, and in spite of the widespread opposition.

Would you agree that you would carefully monitor this situation over the next few months, and if the facts warranted, and if the apprehension and opposition do not abate, to re-examine your position?

Mr. TURNAGE. Indeed, sir. I should also suggest, Mr. Hammerschmidt, at this time that we have had, notwithstanding the inference suggested in your question, every assurance now, based on the statement that was made to the people involved in this process by the current Chief Medical Director, Dr. Ditzler, as well as his deputy, who is represented here this morning, that, in fact, the attitude about getting on with the job and achieving the objective has been a most positive one. I would look forward to a review by this committee of the progress achieved at some suitable time in the future.

Mr. HAMMERSCHMIDT. As we know, the Chief Medical Director has just requested reassignment to the VA medical center in San Francisco. He opposed part of your reorganization plan, particularly that part concerning the Central Office engineering function.

What connection, if any, is there between his opposition and his reassignment?

Mr. TURNAGE. I'm sure there is no tie between those two actions, Mr. Hammerschmidt. As a matter of fact, we have had disagreements on other issues simply based on different philosophical approaches. None of those has been acrimonious or none of them has been to the point where there are any personal issues involved. It has been a matter of approach or management style.

The Chief Medical Director informed me as early as a month ago of his thinking, his consideration of other possibilities for the future. The job he is currently in involved a 4-year appointment, and he was looking for those options that would, in effect, put him back in a mode where he would have tenure and continuity in the system. He made that choice, not I, sir.

Mr. HAMMERSCHMIDT. Fine. Well, you know, we hear rumors, and you know how stories are in the bureaucracy, and particularly on Capitol Hill. I think these hearings are a good place to clear the air and to bring some facts out and into the record. I appreciate your response.

Mr. TURNAGE. Thank you, sir.

Mr. HAMMERSCHMIDT. A new Chief Medical Director will take over a department of the VA which has over 200,000 employees. Can you tell us what your plans are at this time with respect to the selection of a new Director? Are you able to say if he or she will come from within the Department or from the outside?

Mr. TURNAGE. Sir, I have no preconceived notion about that particular issue because, first of all, it was only last Friday that Dr. Ditzler, by letter, announced to me that he elected to take on a new role in the system. I am conscious, however, of some very important qualities that must be associated with a new Chief Medical Director. He must have medical eminence in his field; he must have administrative capability. We have every view from the veterans' service organizations of their preference for a veteran who understands the sensitivity to that side of the equation. We find that, all things being equal, if we can bring someone from within the system, it seems appropriate to do that.

However, I think the field should be open to consider all qualified candidates. I would not do that in a vacuum, Mr. Hammerschmidt. We would ask for a board or a panel or a committee that we will put together to find the best talent available that would be willing to serve the Nation in that capacity.

Mr. HAMMERSCHMIDT. Dr. Donald Custis, the former Chief Medical Director, a most respected individual, advises the committee of his opposition to much of your reorganization. He also suggests that he could make a compelling case for the return of the supply function to the Department of Medicine and Surgery.

My question is, did you consult with Dr. Custis or other former Chief Medical directors, or with any other prominent medical administrators, in either the private or public sector, before you made your reorganization decisions?

Mr. TURNAGE. I have not consulted with prior Chief Medical directors. I have consulted with people in our Central Office; I have consulted with people in the field on every occasion that I've had that opportunity; I have consulted with former Administrators.

However, notwithstanding the distinction with which Dr. Custis served and the contribution he made to the system, we note that the issues still prevail, according to the Booz-Allen and Hamilton report, and that corrective actions must be taken. It is in that direction and for that purpose that we have made the decision we have and plan to get on with it.

Mr. HAMMERSCHMIDT. Thank you, sir. Thank you for your testimony and for your responses.

Mr. DASCHLE (presiding). Thank you, Mr. Hammerschmidt.

Our chairman of the full committee, Mr. Montgomery.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

General Turnage, thank you for being here this morning. I think it is very important to the subcommittee that we hear from you. Thank you for coming on the Hill. I know you have many responsibilities, but I also think one of your responsibilities is to come on the Hill and work and talk with this committee, as you are doing this morning.

I don't have any problems with reorganization of the Veterans' Administration in the construction field, but I am concerned that

you are shifting a lot of responsibilities, as I interpret it, from the Director of DM&S over to your office.

Now, I like somebody to take charge, but still, I think you have to have some input from the Director of the Medical Services. That has given me some concern.

I know you answered Mr. Edgar and also Mr. Hammerschmidt, but still, the way I interpret it, you're just about going to bypass the Director of Medical Services, if you want to, under this proposal you submitted here today.

Mr. TURNAGE. Mr. Chairman, if you have concern, based on the contribution you have made to this committee, I certainly share that concern then, and I would like to try to change that perception.

There is no intention, by organizational structure or by design, or weaving into the pattern of the system, to permit an opportunity, a technique or a procedure by which the Chief Medical Director could be bypassed. What happens is that simply, as opposed to having fragmented organizational entities that can impact on the system, if we can put it into one structure where it would be, in effect, a one-stop shop operation, it does not diminish in any way, from our perception, the overall responsibility for the initial planning and the establishment of needs on a prioritization basis by the Chief Medical Director to the Administrator for the requirements associated with his needs. The MEDIPP process stays completely in the DM&S structure.

His input from the standpoint of medical planning and those entities of his staff which would give him an opportunity to impact on that system, his right to present those options and recommendations to the Administrator, none of those aspects have been diminished in any way whatsoever.

The fact is, even under the current system, under the MEDIPP process, the ultimate recommendations that come forward and that are developed by the Chief Medical Director still come to the Administrator for final decision. That would not be changed in the new process.

An emphasis that I would like to make in reiteration of something stated earlier, is that the initial plan which was advocated by my predecessor was to do precisely the same thing, except putting the entire operation under DM&S. We are suggesting the same essential organizational structure, but leave it in a central type staff operation which serves the entire agency, not just one part of it.

A typical case—and it is not absolutely correct, but it is a close enough corollary, I think, that it has some significance—is the fact that the Department of Veterans Benefits spends more money now out of the VA budget than DM&S does. No one would suggest that we put the controller's operation under DVB simply because it spends more money and expect that it would, in turn, give objective-type treatment to the other departments and offices within the VA.

I perceive the same thing to exist, at least in some measure, organizationally with the proposal that had been presented to this committee before; that is, to move the entire construction system under DM&S. It is something that serves the entire agency, not one part of the agency, and it is something for which, according to

the statutes, I have the ultimate responsibility. I don't have the concerns that have been expressed, and I think some of those concerns were generated by the rumors that Mr. Hammerschmidt referred to.

Mr. MONTGOMERY. General Turnage, I can only speak for myself, but I think most members on this committee feel like I do, that we don't want to really get into this with the committee—and we have done it several times and I haven't felt comfortable with it—of maybe spelling out in language, even in a bill, that certain hospitals will be built. We think that is your responsibility, or even outpatient clinics. We don't want to get into that, but we want the system to be fair. That's why I'm sure this hearing is being held today, to find out that you have the responsibility. But we certainly want, especially the Director of the Medical Services and his team, to be considered when sites are picked and large amounts of money are being spent for the building of hospitals.

Mr. TURNAGE. Mr. Chairman, may I say this. There is no decision that I make in my current capacity that is accomplished in a vacuum. There are three very critical people to the success of the system. The Chief Medical Director is at the top of that apex, and I recognize the contribution that he must make, and I recognize the confidence that I must have in him.

Decisions relating to these subjects or to DVB or Memorial Affairs or otherwise are always done in a forum, where we get the best views available before the final decision is made. Once that decision is made, then it is that time that I hope all people who are responsible for it get on board and make it work.

Mr. MONTGOMERY. Thank you.

My time is up, but let me comment on one other area. On the sharing agreement between the military and the Veterans' Administration which is moving forward. It is a good buy for the taxpayers to share our medical facilities between the military and your shop. Also, I think the patients get better treatment. So I will watch that very closely, General Turnage. We would like to push that sharing agreement. It is working well and it has finally gotten off the ground. The Air Force has been more cooperative than the other services, and we think it's very important.

Mr. TURNAGE. Sir, we know of your interest. We are pushing it and we will be glad to keep you advised about the progress we make.

Mr. DASCHLE. Thank you, Mr. Chairman.

Mr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you very much, Mr. Chairman. May I also express my appreciation for your being here and those that came along with you. I have a couple of questions, Dr. Gronvall, that I would like to ask you.

If engineering services is moved, as is now planned, do you foresee any problems with that, and if so, what are those problems?

Dr. GRONVALL. Mr. Rowland, I think that's a hard question to answer. The Administrator, Mr. Turnage, has described the work that is now going on as a major collaborative effort between people in DM&S and in the Office of Construction to move smoothly through this transition period, move the engineering Central Office

staff to the new Office of Facilities, and ensure that there is a smooth working organization so that the total enterprise goes on.

As has been previously said, the Department expressed the view that there were strong advantages to having the group of engineers in the Central Office be in the DM&S organization. That matter was discussed and a decision was made, and I think we are now trying to put all of our effort, as I say, into ensuring that the new organization will work. So it is really hard for me to make an informed projection that down the road this or that specific problem will occur.

Mr. ROWLAND OF GEORGIA. You're not clairvoyant, then?

Dr. GRONVALL. Correct. And I've known that, and I think this committee has known that, also from previous experiences.

Mr. ROWLAND OF GEORGIA. Let me ask you another question.

It is my understanding that you had raised some concerns with the committee staff about this earlier. Now that the Administrator has made his decision to take effect on October 1, have your views changed relative to those concerns?

Dr. GRONVALL. We met earlier with committee staff and, by prior agreement, it was agreed that the purpose of that meeting was to discuss freely the background and the process by which this decision was proposed, reviewed and made. So I described freely concerns that the Department has strongly expressed.

Again, I think those concerns were discussed by the Department, the Chief Medical Director, and also me, directly with Colonel DeWire and General Turnage. A decision was made taking our views, as well as other comments throughout the agency, into account. And so, again, I think the current posture of the Department—and we had said that in advance, that once a decision was made, we would turn to with all of our energy to ensure that the decision would be effectively carried out and made to work.

Mr. ROWLAND OF GEORGIA. You're comfortable with the decision?

Dr. GRONVALL. I would have to say, if you are looking at me as an individual, I participated earlier in the discussions that led to the comments from the Department about some aspects of the proposed decision that we felt were not to the fullest advantage of the Department. I believe those were valid concerns. I am comfortable that that expression of concern on a couple of occasions was fully heard by the Administrator and then he acted. I believed then the concerns were valid. A decision has been made and my job now is to assist in getting on with it.

Mr. ROWLAND OF GEORGIA. Thank you very much.

Thank you, Mr. Chairman. I have no further questions.

Mr. DASCHLE. Thank you, Mr. Rowland.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Gronvall, basically do you see the process, then, as being one of medical people, DM&S if you will, making requests of needed facilities, and then, once having made those requests, with maybe the requirements for significant construction of certain parts of the facilities, carrying on your medical work? Do you anticipate any problem in terms of having those requests met? It now would be passed over, I assume, to the construction people, where it sounds to me like it should be.

Basically, what I'm referring to is, would there be basic disagreements? Do you foresee there might be disagreements in terms of these requests that you might be making of the construction department?

Dr. GRONVALL. I have to go back, really, Mr. Bilirakis, into your question to say that I believe the presumption stated in your question is not, in fact, how the organization will work.

Mr. BILIRAKIS. OK.

Dr. GRONVALL. The responsibility of the Department of Medicine and Surgery will be to develop and get approval for medical program plans, described as MEDIPP. Those program plans are stated in terms of the kind of medical care to be rendered, the kind and number of veterans who we anticipate will be seeking care, and the array of medical and surgical and diagnostic and treatment programs that will be needed to meet that need.

Those programmatic plans, once finalized and approved, will be turned over to the Office of Facilities. So all of the responsibility then for translating those program plans, medical programmatic plans, into facility needs will be the responsibility of the Office of Facilities.

Mr. BILIRAKIS. So the medical people would be out of the picture at that point?

Dr. GRONVALL. Yes. So the Department will not be making requests for facilities. The Department will be describing its medical plans. The translation of those into facilities, the impact on renovation, modernization of existing facilities, the need to build new facilities, the need to lease or buy other facilities, all of that work will be done in the Office of Facilities based on accomplishing program plans that are developed in the Department of Medicine and Surgery.

Mr. BILIRAKIS. That doesn't sound like such a terrible thing to me. Does it to you?

Dr. GRONVALL. I think that proposes an orderly flow of decisionmaking, yes.

Mr. BILIRAKIS. Yes, General.

Mr. TURNAGE. Sir, can Colonel DeWire make a statement with regard to that, because, being Chief of Staff, he's going to have to orchestrate part of this. I think his contribution here may be significant.

Mr. DEWIRE. Sir, one thing I would like to add is that the total system is dedicated to end user satisfaction. To view the DM&S organizational role are simply the development of the medical care programs and then a complete cut and handover to the Office of Facilities, with the idea that there would not be staff interaction after that point, would be an inaccurate perception.

I would anticipate that there would be a constant evaluation of the requirements of the changing technology, of the updated program requirements, throughout the development of the construction projects.

Mr. BILIRAKIS. So you would anticipate that the medical people would continue as a part of the process?

Mr. DEWIRE. Yes, sir. The division that Dr. Gronvall explained, as far as the planning and programming responsibilities, is correct.

But to take that further to assume there would be no interaction would be a very wrong perception.

Mr. BILIRAKIS. General, have you communicated with the veterans' groups—the VFW, PVA, et cetera—regarding this reorganization, and have you received input from them and considered their input?

Mr. TURNAGE. Yes, sir, we have, on an ongoing basis. As you know, we have continuous interaction with these groups with regard to almost any major concern with which we're involved. We understand that four of them were invited to be before this committee this morning to present testimony. We understand that two elected to come. One, we understand, will support the activity that we have initiated, and we understand that one will express some reservations about it.

PVA, for example, we have considered to have great expertise in this business. I was involved in the review of a medical facility, an SCI facility in Memphis, just the day before yesterday, in which they had been continuously involved because of the establishment of the requirements that they perceive are necessary in order to accommodate their members. So we do involve them on an ongoing basis, and I think the same kind of interaction is continuous.

Mr. BILIRAKIS. Well, General, just a final statement and I'll yield back the balance of my time, if I have any.

Yours certainly appears to be a tremendous history of success. I don't guess there are too many general officers who have come up through the ranks, so to speak, who haven't gone to one of the military academies, and yours is a history of success and of accomplishment.

I certainly don't have enough knowledge in this area to question what you are fixing to do at this point in time. I would say it is incumbent upon us as a committee, and hopefully incumbent upon the entire veterans community, to give you a fair opportunity to see how these moves work. I have confidence that what you are doing here is intended to better the lot of other veterans all over the country and all over the world. Hopefully, that will be the way it will work out.

Mr. TURNAGE. Thank you, sir.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. DASCHLE. Thank you, Mr. Bilirakis.

Mr. Molinari.

Mr. MOLINARI. Thank you. I have but one question.

On page 6 of your testimony you make reference to the transfer of 64 personnel to the Office of Construction, along with supporting resources. There has been a suggestion that that number was a calculated arrangement to stay under the 10 percent shift of personnel and thus avoid the provisions of section 210(b)(2) of title 38.

Could you please comment on that?

Mr. TURNAGE. Yes, sir. First of all, on an ongoing coordination basis, there was interface between the Chief of Staff, the other staff agencies, and the Department of Medicine and Surgery when it was determined that we would be moving part of the FEPAC operation into the Office of Construction—what part of that would be moved and what part reasonably should remain with DM&S as a matter of supervision from that Department.

I understand—I wasn't personally involved in it—but I understand that they went through and selected those aspects of the structure, of the operation, which should properly remain with DM&S. It includes things having to do with fire and safety, some ADP work, some other similar type functions which really weren't as germane to construction and engineering as the other functions. It was on the basis of the coordination within the agency that that decision was made.

Moreover, the final determination was made that the nine people who would remain there would be assigned on the basis of the option of the Chief Medical Director, to be used in the most effective organizational structure that he perceived. There was no objective, from our point of view, of circumventing any of the laws or the requirements or options available to us. According to my track record, sir, that is not one of my techniques.

Mr. MOLINARI. I am pleased to hear it. Thank you very much. I have no further questions.

Mr. DASCHLE. Thank you, Mr. Molinari.

Mr. McEwen.

Mr. MCEWEN. Thank you, Mr. Chairman.

General, those of us who are very supportive of your expected success as Administrator are delighted that you made the effort to be here today. I thank you very much for coming.

I have a question that is very much unrelated to the discussion here this morning, but I wanted to present it.

The VA medical center at Chillicothe, Ohio has been a topic of discussion in our southern Ohio community; we hear that there is a possibility of reducing the number of hospital occupants to the level whereby it can be closed by action of the Administrator.

I am sure that's not the case, and I would like a statement from the Veterans' Administration as to exactly what the intentions are for the use of that facility in the next 5 or 6 years, as well as for the construction plans. If I could ask that of you, I would be grateful if you could respond.

Mr. TURNAGE. If I may, I would like to provide more detailed information for the record.

Mr. MCEWEN. Please.

Mr. TURNAGE. Because out of 172 of them, sir, I feel remiss that I didn't know precisely about yours.

Mr. MCEWEN. That's exactly right, and I understand. However, due to the fact it has come to my attention in the last couple of weeks, I wanted to take this opportunity to present it and clear it up for the record.

Mr. TURNAGE. Let me suggest to you the ongoing process, Mr. McEwen, which ultimately generates some concerns, some rumors, and some dissatisfaction overall.

The evaluation of the system is an ongoing process, and the Chief Medical Director is looking at it on an ongoing basis, based on the patient load, the type of patients' needs that are inherent in the particular area we're talking about, the trends that are reflected in the area and otherwise. And on that basis, in some cases we consider changes of mission, to, in effect, take part of the hospital and make it a nursing home, or we will enlarge another aspect of the

outpatient clinic as opposed to the inpatient care and so forth. So it is a dynamic system which requires constant review.

Just the fact that it's reviewed, you can understand, causes some of the issues that you're discussing. I don't know the specifics of yours, but we would be glad to provide that for you.

Mr. MCEWEN. I thank you very much, and thank you again for your testimony.

Thank you, Mr. Chairman.

Mr. DASCHLE. Thank you, Mr. McEwen.

Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman. Welcome to the committee, Mr. Turnage.

Mr. Chairman, if I might ask unanimous consent that my statement be included in the record.

Mr. DASCHLE. Without objection.

[Prepared statement of Hon. Tim Penny appears at p. 105.]

Mr. PENNY. I have an interest in the planning process down at the VA. In my statement I mentioned that it's not necessarily an issue that is near and dear to my heart; it is more like a thorn in the side, because I haven't seen the kind of long-range planning down at the VA that I think you need. It is not peculiar to the VA, but I think it is throughout the bureaucracy and even here in Congress that we're guilty of falling short when it comes to long-range planning. So this morning I am quite interested in learning a little more about your strategy for facility planning within the VA.

I am aware that in making your recommendations for a new office in this regard that you asked for comments on that proposal from the DM&S staff. It is my impression that in your final plan you didn't respond specifically to those recommendations from the DM&S staff and, in fact, didn't incorporate much of their advice into your final decision.

Would you care to react to that and explain why it is that people that have been involved in this process all along were not listened to more carefully in coming up with your new strategy for planning?

Mr. TURNAGE. There are three or four parts to your question, but one I can answer definitively. There has been no reservation or concern or issue that has been raised with me or the Chief of Staff that has not been responded to. If someone has something specific they would like to make to us in that regard, we would be pleased to listen to it. But what I am responsible for doing is making the decision based on a statutory requirement and responsibility. I made that decision, but it was not done in a vacuum. We sought, on a continuous basis, all the views that we could so that we could put it into the crucible of thinking.

So the concerns or reservations that had been expressed by anyone have been met with a response and a rationale for the position we took.

Mr. PENNY. The understanding I have is that the senior staff at DM&S specifically opposed the change that you are now undertaking. What kind of response did you give them for moving forward with this change in the planning process, when apparently by unanimous recommendation they opposed it?

Mr. TURNAGE. The planning process known as MEDIPP which determines the requirements for the system, sir, has not been changed. That will continue in the structure just the way it was before.

Mr. PENNY. But what you have done is moved out of DM&S the kind of direct involvement they have had in planning in the past. I think that is what they objected to.

Mr. TURNAGE. If you will also note, sir, that according to Booz-Allen and Hamilton, for which we spent a million dollars, they said that the fragmentation of the system and the system as it had been in vogue was, in effect, inefficient and really contributed to part of the problem. This is what we're trying to correct.

Mr. PENNY. How many employees of the Facility Engineering, Planning and Construction Office have you retained within DM&S?

Mr. TURNAGE. Nine, sir.

Mr. PENNY. What will their function be now that you have made this reorganization?

Mr. TURNAGE. Let me be more precise and tell you precisely what those functions are.

They will be doing occupational safety and health and fire and safety work; they will be doing support.

They'll be doing ADP support and budget interface; they will be doing facility activations. Those are some of the functions that, based on coordination with the Chief Medical Director, were determined should remain with his office.

Mr. DASCHLE. Will the gentleman yield for just a moment?

Mr. PENNY. I would yield.

Mr. DASCHLE. I was going to withhold my questions until after everyone else had had an opportunity, but there is a pertinent question to be asked at this moment, I think, because we're on an important issue. The General mentioned that we spent a million dollars with Booz-Allen to come up with this study.

I would ask, did they recommend that this function be taken out of the DM&S?

Mr. TURNAGE. According to my understanding, they recommended—and correct me if I'm wrong—that because of the fragmentation of the system, the system should be, in effect, in one entity, as opposed to the two separate entities, where we find it now.

Mr. DASCHLE. But that doesn't answer my question. Did they actually recommend moving it out of DM&S?

Mr. DEWIRE. If I may expand on that, sir, the original study came up with three recommendations: leave it as it is, a partial consolidation under DM&S, and a partial consolidation under the Office of Construction. In the review of that initial study by Administrator Walters and his staff, it was determined that that did not go far enough and it was asked that two other options be reviewed. One option examined the consolidation of the construction function within DM&S and one option examined the consolidation of the construction function in an independent office. So those five options were evaluated in arriving at the final decision.

Those same five options were available for our evaluation and were all examined.

Mr. DASCHLE. I thank the gentleman for yielding. I will ask unanimous consent that the gentleman have an additional minute to finish his questions.

Mr. PENNY. Thank you, Mr. Chairman.

One last question, Mr. Turnage. Does moving DM&S further out of the planning process mean that OMB moves closer in?

Mr. TURNAGE. I'm sorry?

Mr. PENNY. Does moving DM&S further out of the planning process mean that the OMB, the Office of Management and Budget, is moving closer into involvement in the planning decisions at the VA?

Mr. TURNAGE. I don't see any relationship, sir.

Mr. PENNY. Well, I think there has been, over the time I have served on this committee, a determined effort on the part of OMB to inject itself into some of the construction decisions and other planning decisions in the VA. I think a lot of us in the veterans community are quite sensitive to that development. We would be very reluctant to embrace a change in the structure within the VA if we felt it would strengthen the hand of OMB in opposition to the kinds of interests that we would like to think the VA serves on behalf of American veterans.

Mr. TURNAGE. Let me address the crux of the question, and that is the concern of removing the CMD from the planning process—that is not the fact. If it's a perception, it is misplaced, in my judgment. The fact is, the installment of requirements based on needs, and based on the veteran community and all aspects of the medical care that are required, still are in the Chief Medical Director's purview. We ask for his continued input, establishing his requirements on an ongoing basis, and the continued evaluation of that.

Once those needs and requirements are known to the Administrator and chopped on, then we tell, in effect, the Office of Construction to perform, to meet those needs. So DM&S is not devoid of being involved in the planning process. It is not perceived that way at all. That is a perception that some people want to have, simply because of other interests, which I can't understand.

The fact is the field, though, doesn't feel that way, Mr. Penny, based on my own personal involvement with the determination of that fact. They see that what's happening now is exactly what Booz-Allen saw, that it's a fragmented system that takes too long to accomplish its objectives, and we have made some very grevious mistakes along the way with it. We think by putting this function in one central location it is easier then to assess responsibility for action or inaction and we can take the necessary corrective requirements that are necessary.

But on the complete ongoing system, they are not separate and distinct. They are involved, they coordinate. It's a continuous action where the field and construction will be mutually complementing each other's requirements.

Mr. PENNY. Mr. Chairman, I think my time has expired.

If Mr. Turnage has some observations on the involvement of OMB in this whole business, I would appreciate his elaborating on that. With that, I have no further questions.

Mr. DASCHLE. Following up on the gentleman's questions, I would ask what role did the Chief Medical Director play, General Turnage, in the budget formulation process?

Mr. TURNAGE. I can't speak for the past, Mr. Chairman. I can speak for the process in which we're currently engaged, working on the 1988 budget.

Mr. DASCHLE. What role would he have then in that budget?

Mr. TURNAGE. He has a very vital role. In effect, his role is responsible for telling us his projected needs based on the requirements as he sees them. We gave some very basic and simple guidance, from my perspective, at least. We stated to each of the individuals responsible for contributing to the budget for the overall VA requirement that they were not to be constrained by other than what they felt their absolute needs were based on fact, and that we would examine each of them based on merits. But if they couldn't justify them based on fact, then don't ask for additional funds for any area.

But the fact is, we asked them to take the most objective, positive view about their requirements in the future, without concern for any other factors, Gramm-Rudman or otherwise, tell us what they were. Then we would massage them at our level to make the final determination of what our position would be for the VA.

Mr. DASCHLE. If OMB doesn't agree, what role will either the Chief Medical Director, or anyone else within the VA, play with regard to appeal of budget passbacks?

Mr. TURNAGE. I have the primary responsibility with OMB, as you can appreciate. That fact notwithstanding, on an ongoing basis—and I would presume as currently as this week—we have had people from various departments of VA involved in interface with OMB defending their positions and defending the requirements that they have asked for. That is not exceptional; it's the norm.

Mr. DASCHLE. What about the appeal itself? Will the Chief Medical Director have an opportunity to appeal a budget passback?

Mr. TURNAGE. I'm sure he will, from our point of view, and I'm sure also he would be asked, just as we have other representation here in this forum, that he would have opportunity to be in the forum at OMB to make his issues known.

Mr. DASCHLE. So you will not deny the Chief Medical Director the opportunity to appeal budgetary passbacks?

Mr. TURNAGE. Sir, I haven't denied anyone the opportunity to do anything, even pass unfounded rumors.

Mr. DASCHLE. Well, we want to thank you for clarifying that.

Obviously, General Turnage, you have inherited a number of organizational and reorganizational challenges and problems. Some of them are general and some of them are specific.

As you know, in South Dakota we have a specific reorganizational problem, and I want to direct some of my questions to that specific situation.

As you know very well, in January of 1985 an investigative team recommended that Mr. Woytassek, the Director of the Fort Meade facility in South Dakota, be replaced. Why has it taken the VA a year-and-a-half to deal with that report?

Mr. TURNAGE. I can't second-guess the past, Mr. Chairman. I have been here a little less than 5 months. That report was acted on by my predecessor, first I presume within the Chief Medical Director's office, and I presume—and I am only emphasizing presumption because I don't know the process at that time—I presume it must have been chopped on by the Administrator or his Deputy. That action preceded me and I wasn't privy to it.

Mr. DASCHLE. Well, several months after that an investigative team screening committee met to review the report, as well as Mr. Woytassek's response. What conclusions did the screening committee reach?

Mr. TURNAGE. What was the time frame for this? The reference is not clear to me, sir.

Mr. DASCHLE. The screening committee met, as I understand it, sometime in the summer of 1985 and made its conclusions at some point after that.

Mr. TURNAGE. Once again, sir, I came in March 24, 1986.

Mr. DASCHLE. Well, are you not aware of the final report of the screening committee?

Mr. TURNAGE. I have read that report, sir. I provided you a copy——

Mr. DASCHLE. That's what I'm asking.

Mr. TURNAGE. Yes, sir. When you say screening committee, I provided a report that was made of the committee that went to the hospital to make a determination about the effectiveness of the Director.

Mr. DASCHLE. But there was also a screening committee report following that report by the investigative team. I'm asking the status of the screening committee report.

Mr. TURNAGE. I understand that was a report that came forward to DM&S recommending certain actions. I presume it was also consistent with the Regional Director's recommendation at that time. The DM&S, according to my understanding, made a decision to the contrary and left him in his position, hoping that he would continue to develop his professional skills and perform his role the way they considered his potential to suggest.

Mr. DASCHLE. So the screening committee report overruled the investigative team; is that what you're saying?

Mr. DEWIRE. The screening committee report, as I understand it, to include the recommendation of the Regional Director, was for transfer of Mr. Woytassek. In fact, it was determined in the Department of Medicine and Surgery, upon their review, that he should be retained in that spot and monitored carefully.

Mr. DASCHLE. So, in essence, they overruled the investigative team?

Mr. DEWIRE. That is correct.

Mr. DASCHLE. We have recently requested a copy of the screening committee report. Could we receive a copy of that report by the end of this week, General Turnage?

Mr. DEWIRE. Sir, we submitted a copy of all the reports that were associated with that particular investigation.

Mr. DASCHLE. We have not yet received the screening committee report, though.

Mr. TURNAGE. That's the basis for my response to your earlier question. I'm not sure I know the distinction between the screening committee report and the initial report of the investigation. I thought we had provided you with what we had.

Mr. DASCHLE. As I understand it, General Turnage, there is a report which analyzed the investigative report, including Mr. Woytassek's response, and that is called the screening committee report, which I am told was turned over to your predecessor and ultimately has been pending now for some time.

You're saying you're not aware of the status of that report, or the whereabouts?

Mr. TURNAGE. I will be after we leave here.

Mr. DASCHLE. OK.

Mr. TURNAGE. I am familiar with the report that was made by the investigative team that went to the medical center. I then provided you a copy of that based upon your request.

Mr. DASCHLE. And I appreciate your cooperation in that regard very much. What Mr. DeWire is telling me, though, is that the screening committee, in a sense, overruled the investigative committee, which maintained that Mr. Woytassek should be replaced. The screening committee's overruling the investigative committee then allowed Mr. Woytassek to stay for approximately 18 months since the investigative committee's report; is that not correct?

Mr. DEWIRE. Sir, that is not correct. That is not what I intended to say, if I said that. My understanding is you have the investigative report, which was concluded in January 1985. There was then a board convened and another recommendation made. Now, I don't know whether there was a report or not. In response to your request for a report, I had requested those reports that existed. I thought we had sent those forward. But a determination and recommendation was made in July of 1985 to the Chief Medical Director that Mr. Woytassek be replaced.

Mr. DASCHLE. Right.

Mr. DEWIRE. At that time, the decision was made within DM&S to overturn the recommendation, or not to act on that recommendation in that way, but rather to retain him.

Mr. DASCHLE. What was the basis for that decision, Mr. DeWire?

Mr. DEWIRE. Sir, I do not know. As I say, it was before we were there. It was made in the office of the Chief Medical Director.

Mr. DASCHLE. Dr. Gronvall, could you elaborate on that question?

Dr. GRONVALL. First a general comment.

I think the fact that in an instance where a difficult decision is to be made, it is not uncommon that a team might visit a medical center, collect evidence first hand, prepare a report and make specific recommendations which, when they are reviewed in a broader context by the person—in this case, the Chief Medical Director—who is ultimately accountable for taking management action, often the final decision for action may be quite different than what is recommended by a team that did a special study and made a recommendation based on a narrower set of issues.

A year ago, when that recommendation was reviewed by the Chief Medical Director, and when he sought the advice and commentary of other officials in his Washington office, his conclusion was that, on balance, at that time a more appropriate judgment

was to not make a change in the Director of the medical center but to engage in certain additional monitoring functions, make clarifications to the staff at the medical center about what was to be expected, not only from the Director of the medical center but from other members of the staff at the medical center, during the coming months and monitor the situation.

I believe that that process was appropriate and not a unique kind of instance in terms of a final action being different than what was recommended at one point in time.

Mr. DASCHLE. And yet you had the Regional Director telling Fort Meade doctors, as well as my staff, in November of 1985 and through the spring of this year, that Mr. Woytassek would be leaving.

On what basis was he providing us that information if that decision had been made?

Dr. GRONVALL. Of course, I was not a part of any communication between the Regional Director and your office. The fact is the Regional Director is a part of an administrative team. He is responsible for making recommendations, but he is not the official who acts with authority to move personnel. So whatever he would say at any given point in time I assume would be what he might be recommending, but he is not the responsible action official.

Mr. DASCHLE. Well, as you can understand, there has been a tremendous amount of confusion, and as late as just a couple of months ago, it was understood the VA had arranged to transfer Mr. Woytassek to Montana, that he had agreed, and that those transfer orders had been cancelled.

Is that accurate?

Dr. GRONVALL. That is not an accurate statement. No decision by a responsible official was made to transfer him.

Mr. DASCHLE. Well, this confusion has obviously caused a great deal of concern and frustration on the part of doctors, as well as on the part of many of the patients at Fort Meade. You have just recently sent an investigative team out there again to report their findings back to you, with some recommendations.

Can you elaborate on the findings of the investigative committee and your actions as a result of their having been to South Dakota?

Mr. TURNAGE. I can relate that I have met with that team as of yesterday afternoon, Mr. Chairman, and that the decision is under advisement to me at this time. I expect to have a decision made in that case and action taken before the end of the week.

Mr. DASCHLE. Before the end of the week.

Mr. TURNAGE. Yes, sir.

Mr. DASCHLE. The final concern expressed by many people, all through the veterans' community, is the current status of Fort Meade. As you know, well before you arrived, General Turnage, there was some concern about whether or not its priority was going to be in question; there is some concern about whether or not its role was going to be fulfilled, and ultimately whether that role would be changed in any way.

Can you make a commitment to me today that, number one, Fort Meade will not be closed, nor its role be changed in any way?

Mr. TURNAGE. I can make a commitment to you that Fort Meade is not scheduled to be closed at any time that I know of, and I have

not even heard that addressed. I cannot make a commitment to you that there would not be any change in the status or mission of that operation in the future because, if I were to do so, I wouldn't be completely honest with you. I don't know.

We do have, however, as I suggested to Mr. McEwen earlier, all hospitals—not just Fort Meade, or not just Miles City, or not just Walla Walla, or not Houston or any other—we have all of them under constant review, based on demographics and all the other variables which I suggested. For example, within all the hospitals, we are also looking at the cardiac surgery capabilities of each and the number of episodes they perform and all these kinds of things, to include, for example, mortality rates. All of those things, sir, are under review.

I can tell you that there is no discussion from my perspective or information about closing that hospital, but it would be under review like all others.

Mr. DASCHLE. What about closing any one of its functions?

Mr. TURNAGE. I can't tell you that, sir, because I don't know.

Mr. DASCHLE. By saying you can't tell me that, can that in any way be interpreted as the anticipation that some change may be occurring?

Mr. TURNAGE. No, sir. Let me suggest to you that there are no nuances in my responses to you. They are completely up front and completely candid.

The point is, all the hospitals are under constant review for their continued mission.

Mr. DASCHLE. But that's a general statement.

Mr. TURNAGE. I don't know precisely about that particular one.

Mr. DASCHLE. You do not know whether there is any specific evaluation with regard to mission change currently underway with regard to Fort Meade?

Mr. TURNAGE. Let me ask. Dr. Gronvall, do you know of any?

Dr. GRONVALL. Honestly, Mr. Daschle, I can't tell you of my own knowledge that there is or is not a specific mission change being proposed for the Fort Meade medical center.

I would really repeat what Mr. Turnage has said. Those kind of plans for mission change, in fact, are underway for virtually every medical center——

Mr. DASCHLE. I understand that.

Dr. GRONVALL (continuing). As every medical center looks to the future.

Mr. DASCHLE. I understand that.

Dr. GRONVALL. I am not aware of a specific plan that would change the Fort Meade mission in a major way. That does not mean that option does not exist at some level within the Department. It may well. But again, those plans start at the local level; they are developed at a district level; reviewed at a regional level; and finally, they are presented in Washington as recommendations for action, which may or may not be taken, based on a lot of other factors.

Mr. DASCHLE. As you may or may not know, Dr. Gronvall, several years ago an effort was made to remove the department of surgery from Fort Meade. That was rescinded and, as a result, we have a very fine surgical unit at Fort Meade, and we're very proud

of it. We certainly don't anticipate the need for change at any time in the near future.

Obviously, if you're not aware of any specific recommendations or proposals at this point to make any mission changes at Fort Meade, that's gratifying to me. But, for the record, I would like you to elaborate on your answer in that regard. If there is something, we would like to have it submitted for the record and a report provided to me personally.

Could that be done, General Turnage?

Mr. TURNAGE. I understand.

Mr. DASCHLE. Very good.

And as I understand it, once again for clarification, by the end of this week you will have a response with regard to the Administrator of Fort Meade?

Mr. TURNAGE. That's correct.

Mr. DASCHLE. And you will also try to find the so-called screening committee report and the recommendations therein?

Mr. DEWIRE. That is correct.

Mr. DASCHLE. Very good.

Let me turn again to a more general purpose. You have elaborated extensively with regard to some of the committee's questions already, but I am concerned about the role that the Chief Medical Director played in this process. I know you have responded extensively in that regard.

But as I understand it, the decision was made based upon the Booz-Allen options. There were five options presented, and four of the five options presented recommended an inclusion of these responsibilities under DM&S. One did not. You chose the one that did not.

You then gave the Chief Medical Director an opportunity to respond. He made three appeals. In each one of those instances, the appeals were rejected. Is that understanding correct?

Mr. TURNAGE. No, sir, that is not correct.

According to what I understand of your statement, the decision was made and then an opportunity was given to the Chief Medical Director to make his reservations or concerns known. The decision was not made first. What we did, we talked to everyone in the agency first. I talked with some 16 or 17 medical directors in the field first. After we reached a certain point, the paper was sent through the agency—we had at least two or three drafts that went through the agency in each case—finally, after each individual had an opportunity to make his input known to us, notwithstanding the fact there wasn't complete agreement at that point, we still made the decision.

Mr. DASCHLE. If you could provide for the record, who were the major architects of your construction reorganization plan?

Mr. TURNAGE. The principal architect, who did the coordination within the staff—and it rightfully should have been, based on his job—was the Chief of Staff, Colonel DeWire.

Mr. DASCHLE. Were there any "hands on" planners representing the Chief Medical Director's office involved in the planning process which resulted in your June 3 memorandum announcing your reorganization decision to your staff?

Mr. TURNAGE. I can't tell you that. I would hope that the Chief Medical Director would have called all the expertise that he would have wanted to forward to give him their views before he took the position that he did with me.

Mr. DASCHLE. I don't understand when you say you can't answer that.

Mr. TURNAGE. I don't know the machinations that went on within the CMD and his shop, DM&S, based on the fact that we then were sending throughout the agency this proposal.

Mr. DASCHLE. We're talking prior to that, General Turnage, on June 3, prior to that time.

Mr. DEWIRE. Sir, if I may.

Mr. TURNAGE. Sure.

Mr. DEWIRE. What happened prior to June 3 was an evaluation on the part of myself and the Administrator, inasmuch as he was briefed very early on the Booz-Allen report, an evaluation of the various options, consideration of the concerns that had been raised by the Administrator and other aspects of the organization. Then, based on that evaluation and general guidance, an initial rough draft was put out.

Now, the Chief Medical Director participated—inasmuch as all the staff participated in their familiarity with the Booz-Allen report—and he provided a specific briefing for the Administrator on the reorganization of construction prior to 3 June, as did the ADA for Logistics. We had two separate briefings to get two points of view.

All that input and those briefings were considered prior to my development of the first draft package that was submitted for staff coordination on the 3rd.

Mr. DASCHLE. Don't you make a distinction between briefing and planning? You're talking about briefings here, not planning.

Mr. DEWIRE. Sir, I would submit the planners provided their input to the CMD briefing. It is also important to understand that what was put out on the 3rd was a first draft, where every department had the opportunity to involve whomever they chose to involve in the review of that draft and the development of comments to that draft.

Mr. DASCHLE. Did you accept any of the input from the department heads?

Mr. DEWIRE. Yes, sir. As a matter of fact, many of the inputs from the different departments were accepted. This was staffed throughout the agency. There was quite a significant modification, some technical aspects, in addition to some procedural aspects, between the first and second drafts of that.

But it is important to also understand that that is the normal staff process.

Mr. DASCHLE. You said you accepted. Did that include the CMD?

Mr. DEWIRE. A portion of CMD's comments, sir, but not all of them, certainly.

Mr. DASCHLE. A portion?

Mr. DEWIRE. Yes, sir.

Mr. DASCHLE. Well, whatever portion was accepted, it led him to appeal on three different occasions, that the plan as it was finally

drafted was not acceptable to the Department of Medicine and Surgery. So, obviously——

Mr. TURNAGE. Mr. Chairman, it was never put that way. I talked with Dr. Ditzler personally about this, because he would come in to me expressing some of his concerns. He not only would express them personally, vocally, but he would give me a piece of paper relating to those concerns. We would discuss them and then we would come back with the rationale for it and return them to him. He had the option, he had the opportunity on many occasions.

I think the bottom line, sir, from my point of view, is quite a simple one. Booz-Allen and Hamilton said we have some problems in construction in the VA. They should be corrected. We have a fragmentation in planning, and a fragmentation in execution. The field says that.

For reasons that are difficult to understand from my perception, there are some people who prefer not to accept the fact that there has to be change in a system that has a $27 billion budget and 250,000 people working for it. The fact is, it is dynamic. We do have to change and we have to meet the changing needs that are imposed upon us.

Now, I have not only the statutory responsibility but, according to my perception, and according to the information provided by my counsel, I have the authority to accomplish this necessary change in order to meet the responsibilities inherent in the job. I want to get on with this. This all started 2½ years ago. I made a decision because I have seen some things out in the field, as some people right here listening to this must have also seen, that opt against effectiveness of our organization. I want to change it. I have the opportunity to do that and, sir, with your support, I intend to do it.

Mr. DASCHLE. I certainly intend to support you, General Turnage, in this effort if we have obtained a complete understanding of the benefit to the system and to our veterans. We are always concerned about change for change sake, but if we're changing for improvement's sake, then obviously you've got the overwhelming endorsement of this subcommittee and I am sure the full committee.

But the question that keeps coming back is, have you given adequate opportunity for input to that part of the VA most directly involved? The evidence, at least on the surface, is that in spite of their overwhelming opposition, you're going ahead anyway. Booz-Allen gives you five options, four include DM&S, and you take the fifth one——

Mr. TURNAGE. I don't consider the opposition to be overwhelming, sir. For example, I suggested to you—and if there is an issue about my perception of it, someone should check it out—I have been to the field and talked with people who are the recipient of this program. There is disenchantment and frustration there with it. I can give you cases in point where that is the issue.

The fact is, there was some disenchantment with it, and the fact is there was some opposition to it. But to the credit of Dr. Ditzler and to the credit of Dr. Gronvall, they suggested that "when you have made the decision, we'll help to try to make it work." That was the last word that Dr. Ditzler gave to the field, and that's what we're trying to do now—get behind the decision and make it work.

Mr. DASCHLE. But Ditzler had 4 years in his current position; he has consumed 2 of them, and he is now being transferred. You mentioned earlier he has a 4-year limitation, but he has half of that 4-year limitation left, and he's moving out.

Is that in response to his inability to be heard in that position and your determination to see someone more in line with your thinking, or is it just a desire on his part to find another responsibility within the VA?

Mr. TURNAGE. I think the details of that could best be expressed by him, sir. But none of the suggestions, from my perspective, have merit. He came to me a month ago suggesting some alternatives available. As far as I know, it had nothing to do with this particular issue. And then, as of last Friday, he came to me and, once again, I told him some options that would be available if he elected to do it. He chose what he wanted to do. He took the initiative. He did it.

Now, further than that, he should express his views to you, sir.

Mr. DASCHLE. I have additional questions, but, Mr. Rowland, do you have some questions?

Mr. ROWLAND OF CONNECTICUT. Mr. Chairman, I have no questions. I would just like to welcome the general and wish him the best in his new position. If you're half as successful in this position as you have been in your past challenges, I think we're going to be in good shape.

I appreciate your openness and your frank answers. I think you will find that goes well with this subcommittee, as well as the committee. I hope that as we continue to work togther through the rest of the legislative session we can fully anticipate your continued cooperation and your support.

I think you're going to find that this committee, especially in this particular type of hearing, offers us an opportunity to present some of our concerns and some of our priorities. I think you take that in the right spirit, and the fact that you said you will be getting some answers back to us and you will be making some followups I think is the key. I appreciate that very much, and I'm sure the rest of my colleagues do.

Again, I thank you for being here and wish you the best and look forward to working with you.

Mr. TURNAGE. Thank you.

Mr. DASCHLE. I think we can speak for the entire committee in confirming what Mr. Rowland has said.

Mr. Penny?

Mr. PENNY. Thank you, Mr. Chairman. I do have one other item that I want to pursue with the Administrator.

When I mentioned that the planning process left a lot to be desired, I have a specific case in Minnesota that I would like you to be aware of. I have raised this with your predecessor and I have raised it with Dr. Ditzler and others. But I want to sensitize you to this issue. It has to do with the construction of a new hospital at Minneapolis and the use of Building 43 on the current hospital campus once the new hospital is completed. Building 43 is the main hospital building, and it also currently houses the administrative offices for the VA medical center. The plan calls for that building

to be retained once the new hospital is constructed. Many of the other buildings will be razed, but this one is to be retained.

There was at one time a study done within the VA where the possible uses of Building 43 were laid out. We do have other VA functions within the Twin Cities area, and many of them were recommended to be transferred to this building since it is paid for and will be soon available.

Little by little, though, we are losing some of those other VA functions in our Twin Cities area. We are not going to have much to put in this building once it is vacated. It is that kind of shortcoming in the planning process that causes me some concern, that one aspect of the VA is moving forward with a new hospital which then frees up a relatively good building for other uses, and then some of the ideas to which that building was to be put toward are not adhered to and piece by piece some of the uses of that building are being whittled away.

Since this is such a specific item, I wouldn't be surprised if you haven't been appraised of this by your co-workers down at the VA. But it is an example of, I think, poor planning and a lack of coordination and it is something I would like you to address in a general way. But in a more specific vein, I would like to know from the VA that Building 43 is going to have a use and that we will not continue to transfer functions out of the Twin Cities when the original plan for Building 43 was to keep many of these functions—computer services, insurance services and others—in place in the Twin Cities.

Mr. TURNAGE. I am conversant with the issue of the insurance consolidation. I am not conversant with Building 43, per se, although I recall it having been referred to in the overall study, sir. I have, because of the response I have made on other issues, where we talked in terms of excess land and a specific issue, I plan to visit that facility personally at an early date. I think it's within the month.

I think the VFW will be holding their annual convention in Minneapolis and, while there, I will also visit that facility and know more about it myself. At that time I will be better prepared to respond to your questions.

Mr. PENNY. OK. I look forward to visit with you more about this in the future and, if my schedule allows, I will join you for that convention.

Mr. TURNAGE. Fine.

Mr. DASCHLE. Thank you, Mr. Penny.

General Turnage, I have some additional questions, but I think in the interest of time I'm going to submit them for the record, and you can answer them at your convenience.

We are grateful to you for coming. We are pleased that you could answer our quetions and stay as long as you have. We look forward to your returning many times. We appreciate your cooperation.

Mr. TURNAGE. Thanks for your courtesy, sir.

[The questions and their response appear at p. 126.]

Mr. DASCHLE. Our next list of witnesses will be comprised of a panel: Mr. Richard Falco, the former Director of the Facilities, Engineering Planning and Construction Office; Mr. B. Fred Brown, the former Director of the VA medical center in Durham, NC; and

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Mr. A.A. Gavazzi, the former Director of the VA medical center in Washington, D.C.

Gentlemen, we are pleased you are here. Your entire statements will be submitted for the record. We ask, if you would, to summarize your comments and proceed in any way that you see fit.

We will start with Mr. Falco.

STATEMENTS OF RICHARD FALCO, FORMER DIRECTOR, FASCILITIES, ENGINEERING PLANNING AND CONSTRUCTION OFFICE, VETERANS' ADMINISTRATION; B. FRED BROWN, FORMER DIRECTOR VA MEDICAL CENTER, DURHAM, NC; AND ALADINO A. GAVAZZI, FORMER DIRECTOR, VA MEDICAL CENTER, WASHINGTON, D.C.

STATEMENT OF RICHARD FALCO

Mr. FALCO. I would like to thank the chairman and the committee for the opportunity to participate with this panel to discuss the proposal to reorganize the Veterans' Administration construction program. I have recently retired from the Veterans' Administration and am presently employed by Center Properties, Inc., a subsidiary of the Washington Health Care Corporation, as a Director of construction management. I am a registered professional engineer and during my tenure with the Veterans' Administration I have had the opportunity to know and understand the construction program.

I have held several positions in the Department of Medicine and Surgery over the past years. The last position was the Acting Director of Facilities, Engineering Planning and Construction.

I was actively involved in the process that led to the decision by Mr. Walters, the previous Administrator, to seek approval of Congress to consolidate the Office of Construction and Facilities, Engineering Planning and Construction into a new Office of Facilities which would report to the Chief Medical Director.

It is my understanding that the present Administrator has revisited the issue and decided that the consolidation should take place with the new Office of Facilities to be a staff office that will report to the Administrator. I feel this change, which appears minor in nature, represents a major change in the philosophy and management of the construction program.

I would be pleased to answer any questions you may have.

Mr. DASCHLE. Thank you, Mr. Falco.

Mr. Brown.

STATEMENT OF B. FRED BROWN

Mr. BROWN. Thank you, Mr. Chairman. I am very happy to be here at the request of the group to present some background and some experience I have had with the construction program within the VA.

In all of the papers I have been able to peruse this morning, and those that I have seen in the past, I have never seen a reference made to the client which is the end result of the construction process, and that's the veteran patient.

I think also there is a great deal of background encompassed in the word "construction" and I do not believe there is any need or

desire for the CMD to become a construction superintendent. But there is a large element in the process of getting a facility on the ground. It's called planning. That, I feel strongly, is the prerogative to have strong input and a great deal of authority as well as responsibility of the medical grouping within DM&S to say what planning takes place, not so much as to what facility is first, second or third, but when that facility is decided to be built, what's in it, how it is laid out, and the space that is needed for it. I think that's a very important issue to be considered in any deliberations.

If we go back to the Booz-Allen and Hamilton report of 1950—not the recent one—when DM&S was established as a separate department in the Veterans' Administration, it did it on the basis that the program and policies and services rendered to the veteran patient were unique and needed to have the ability to respond quickly to changing needs in medical care in the field, a widely-dispersed geographically operating system. I think over time we have slid away from that. I think that's a special need that always has to be considered in terms of what takes place, in terms of getting facilities ready and operating.

Reference was made earlier this morning that Booz-Allen, Hamilton had five recommendations. I served as the field liaison representative to that group for better than a year and I only recall three organizational recommendations made by the Booz-Allen report. Two that were not included in their formal report were discussed this morning—that is, consolidation of all construction under DM&S, or consolidation of construction all under the Office of Facilities. They were not in the formal recommendations of the Booz-Allen Hamilton report.

That report contained a very strong definition of accountability authority and responsibility for planning for the user and the advocate of the plan, the veteran patient.

Also, I would like to make a case that the engineering service, as presently under DM&S, and has been for many years, is a very important part and very important issue for the Chief Medical Director and medical center Director out in the field to respond to emergencies that do take place. Whether you call it capital investment or an expenditure to maintain facilities is really not the issue.

I have had three experiences in my 17 years as Director in the VA system, plus the other 12 of working in the system, where a boiler blew up on a Friday, and I made a telephone call to my RD that evening, had the money to make sure repairs were underway by Monday morning. My experience for the process within the construction service office, or whichever you call it, you could not get that timely response to get a boiler back on line.

I also experienced a couple of fires that knocked out the telephone switch system and electrical transformers in my career. Again, the ability to respond with a commitment of money, to get those back on line within a day or two, is a very important issue. I would suggest that the construction service has not had that type of response system in the past in any issue I have been exposed to.

Another issue that I think is very important—and I will conclude my comments—there are many technical things which the construction service does which are very important. They do it well. They meet the requirements and specifications, but they sometimes

forget the functionality that exists at a field station that must be met to meet safety requirements and the fire chief's recommendation of the local community you're in.

As another example of that, I happened to be at Durham before I took advantage of my annuity, where we had three separate construction projects which required that fire alarm systems to be tied together. We were going to end up with three different fire alarm systems and three different enunciators, which was not acceptable to the local fire department. It met the technical requirements but not the functional delivery of the safety of patients in the field.

I had the opportunity—I now work as assistant to the Chancellor for Health Affairs at Duke University Medical Center—to read the report that the VA paid a consultant fee to review the cost reduction items that may be related to policies of the VA or the Federal Government, and the specifications that the VA uses. If I read it correctly—and I think I do—there is 105 cost reduction items recommended and forwarded to the VA in February of 1986, and 430 specifications and corrections that must be made from their consultant's point of view that would reduce the square footage cost in the construction process to the VA by $10 a square foot. I think these are the important issues of the construction service, the skills of the engineers, the architectss, should be addressing and the planning belonging to the Chief Medical Director and his staff.

Thank you.

Mr. DASCHLE. Thank you, Mr. Brown.

Mr. Gavazzi.

STATEMENT OF A.A. GAVAZZI

Mr. GAVAZZI. Mr. Chairman, I am pleased to appear before you as a fellow Pennsylvanian. I followed your career and it is a real pleasure for me to be before you and speak as a retiree enjoying retirement.

As you may know, I served 40 years at the VA. I don't know if it's any coincidence, but with the 13th Administrator I had 13 assignments in the field and 2 in the Central Office.

Reorganization is as good as the people you can find to fit the blocks. Putting square blocks in round holes is not going to accomplish anything. It seems to me that every once in a while people try to reinvent the wheel.

I first got involved in the construction program in Brooklyn, NY in 1950, when the Corps of Engineers built hospitals. And then I was at Manhattan. I can tell you that we had many problems that took years to resolve. There was no input, very little input, from the Chief Medical Director or his staff in these construction projects.

In 1963 I was ordered to Central Office to be the Associate Director of what they called then Health Care Facilities Service, which operated closely with the construction program. I was directed by the then Chief Medical Director, Dr. McNinch, to bring in field people to have input in the construction of the hospitals, so that the people who would work in these hospitals would know and have in what they felt would be appropriate.

That later changed to the Hospital Construction Service. And I might add, Mr. Chairman, that during my tenure in Central Office we closed 15 VA hospitals, a traumatic experience that I would never want to go through and one that was political suicide for a number of people. I would not recommend closing any VA hospitals in the future without a lot of thought.

I observed the different back and forth of changes in the construction program, and as Fred Brown brought out, the important item was unaddressed, the patient. I didn't hear anyone mention the patient until Fred brought it up—and I was going to bring it up myself.

Having worked for the VA hospital in Washington, I can tell you one item that originally cost $18,000. It was listed as a stage, rotating. The Administrator's staff knocked that off because they did not read the full paragraph explaining that this would be a stage like you see when you go to a theater, where they would change the stage around to see different parts of the act. It took a year-and-a-half to get that back in the project, at twice the cost, and I don't know how much money would be involved. The Chief Medical Director had no involvement in that situation.

In my view, it would be impossible to have an effective interpretation of programs and construction planning at the medical center level when the responsibilities for basic planning functions are divided between the Office of Construction and the Office of the Chief Medical Director.

If I may, I am reminded of a story of many years ago. Shortly after World War II I came back to Camp Miles Standish in Massachusetts and had the occasion to talk to a prisoner of war who was serving in a mess hall. He was trying to impress me with the discipline of the military in Germany. His story goes something like this:

Five SS recruits were undergoing livesaving instruction at a spa in Austria. They were standing at the end of a large, olympic-sized swimming pool and observing a man going down for the third time. I would like to say this man could be the Chief Medical Director. They were asked by a bystander "Why don't you jump in and save him?" "We can't," answered one of the men, "unless the sergeant comes back with the approval of the lieutenant." This is what would happen if you took health care facilities out and put it in construction.

I'm afraid, Mr. Chairman, in this reorganization we are losing sight of why DM&S exists—to take care of the medical needs of our veteran patients. In my opinion, we are not only reinventing the wheel; we're making a round tire square.

Thank you, sir.

[Prepared statement of A.A. Gavazzi appears at p. 107.]

Mr. DASCHLE. Thank you, Mr. Gavazzi.

Mr. Falco, as the Deputy Director of the Facilities, Engineering Planning and Construction program within the department, you were presumably deeply involved in overseeing the work of the consultant hired to do this study. During that period of nearly 2 years, did you participate in discussions with the consultant concerning the unified program?

Mr. FALCO. Yes, I was part of the committee that dealt with that issue over that period of time.

Mr. DASCHLE. Did the consultant ever express any inclination or strong support for recommending the Administrator move the FEPAC unit entirely into an external organization?

Mr. FALCO. No. As a matter of fact, when they looked at engineering service, they felt there were some technical aspects of engineering service that could be, combined with the technical aspects of the office of construction and achieve some economies. The only debate that took place was the propriety of taking some of the technical people that are presenting in engineering service and putting them with their technical counterparts in construction. There was never any intention to take the maintenance or planning effort out of the Department in our discussions with Booz-Allen.

Mr. DASCHLE. If that's the case, do you think the consultant came to his task with any biases or strongly-held value judgments about what proper organizational placement there would be for construction engineering and facilities?

Mr. FALCO. Well, I thought the consultant did a very good job, and the recommendations that they finally came out with, at least in my view, addressed the issues quite clearly. I think, from their report a sense developed that there would be further economies by consolidating all of construction in one place, and when it was decided to put it in the Department, it didn't appear that it was violating any great principle because the supervisory chain of command over the maintenance and planning effort would have remained intact.

That's why in my statement I indicated that shifting it out of the Department now to a staff element brings in a major change in the philosophy of the operation and takes what has historically been, and I think rightfully, the role of the Department of Medicine and Surgery to manage the maintenance and planning component. I think that from listening to the testimony earlier, the simplistic view that "I haven't changed things much by switching it all to one place that is from the CMD to the staff of the Administrator", is an over-simplification.

Mr. DASCHLE. So you're saying, in essence, that what we are about to witness is a radical departure in philosophy with regard to the organizational responsibilities of the VA?

Mr. FALCO. I think you need to look at how the Department of Medicine and Surgery operates to evaluate this proposal. I think the Department of Medicine and Surgery does a very excellent job in delivering quality health care at a very, very good price. I think one of the major reasons they can do that is because they operate in a highly decentralized mode, where the hospital Director has a great deal of latitude. They have a small central office to support these activities in the field.

I look at what engineering services does in Central Office as part of this vital support to this decentralized operation. I think taking that kind of support out of the Department and putting it together with construction will hurt it. Putting engineering service with construction and making it a staff element, out of the line supervision of the Department, will probably have a very adverse effect on their ability to continue to deliver that quality care.

Mr. DASCHLE. Mr. Brown, would you agree or disagree with the statement that this proposal is a radical philosophical departure from past practice within the VA?

Mr. BROWN. Yes, indeed. It further removes the Chief Medical Director and his staff, professional and otherwise, to have impact beyond participate in determining the future of health care facilities for the veteran patient.

Mr. DASCHLE. As far as oversight goes, obviously this committee is given the responsibility to ensure that our veterans' programs are maintained to the maximum extent possible and that veterans benefits are ensured.

What advice would you have with regard to oversight? What would be the next stage within which we, as a subcommittee, ought to be very concerned as we go through this progression? Is it a couple of months from now? In other words, what is the critical juncture by which we must measure some progress or some major change in the way this thing is working and, for ourselves, be satisfied that it is working adequately or not so adequately?

Mr. Brown.

Mr. BROWN. You're speaking of the announced reorganization by the present Administrator?

Mr. DASCHLE. Yes.

Mr. BROWN. Being as big as the VA is, especially DM&S and the construction process, I think you would not get too much within 6 months. You should have some indication of direction, but I think you would have to look to a year before you got any concrete evidence of things going one way or the other, getting better or worse.

Mr. DASCHLE. Would you agree with that, Mr. Falco?

Mr. FALCO. Well, I think there are many, many issues here and, again, I don't think we can simplistically look at this change and then look to evaluate it because I think the major focus right now is on construction. Yet the things that we are doing that trouble me most are the areas that really are not in construction. I think that the problems that I hear being described over my tenure here and today are probably very accurate with respect to the construction program. I think the Administrator's view that the construction program could be a staff office to him and serve the agency makes good sense and I really don't think it makes much difference from the Department of Medicine and Surgery's view as to where the construction program might be, from the point of view of an evaluation in an x-period of time.

But I do think, because of the manner in which the medical systems operate, the moving of what we know as engineering service in total and making that a staff office to the Administrator will have a negative impact. The difficulty is that it is hard to assess those kind of negative impacts because they don't always come forward in very, very tangible ways very quickly. But the people that work in the medical center need to have quick response time from a group of people relative to the maintenance requirements of the hospital—the procedures, the policies relative to maintenance.

When you umbrella a maintenance operation into a construction operation, you invariably weaken the maintenance because the construction is so overwhelmingly more demanding on the times of the people. So having a separate maintenance arm within the orga-

nization is a very important one. That is what I'm concerned about some kind of immediate, short-range negative impact, I would predict that this could be resolved in a debate about the subject rather than take a "let's wait and see" attitude.

I think the issue of construction is a kind of "wait and see" item, and personally I don't think taking the Department of Medicine and Surgery out of the early planning stages of construction suits me very well. But when you look at the maintenance, that's an immediate kind of response. So I see this as being or greater relative importance.

I would think an open debate about where the maintenance operation is in the Department of Medicine and Surgery would surely reveal that it best remain in the Department of Medicine and Surgery. Where the dividing line might be, where you would split the planning for construction and construction, one might debate that forever. I think someone needs to strongly come and draw that line. But I surely don't believe taking the 5-year facility planning and the early development of projects lends itself to a staff function if the intent is to meet the requirements of the Department of Medicine and Surgery. That chain of command just doesn't work.

Mr. DASCHLE. Let me ask you something. You may or may not be in a position to answer this. But I asked General Turnage whether there was adequate input and consideration given to that input by all department heads. He assured me that there was, including the Chief Medical Director.

Is that your understanding?

Mr. FALCO. Well, I'm sure there was input, but I am also sure that most people who know the system well would argue not to move engineering service out of the Department of Medicine and Surgery, I would think there would be a strong consensus of opinion among the leadership in the Department, at the local and corporate headquarters level, that would argue against that move.

I was kind of surprised to hear that the hospital directors supported moving engineering service out. I think there's some miscommunication there. I would submit that if you talked to 172 hospital directors, you would find an overwhelming majority not going along with the idea of taking the maintenance arm out of the supervisory chain of command of the Chief Medical Director. That can be easily solicited.

Mr. DASCHLE. Mr. Gavazzi, would you endorse what you just heard Mr. Falco say?

Mr. GAVAZZI. Heavens, yes. I would agree with him a hundred percent. As a former hospital director, I would oppose it very strongly. It's a disaster to take engineering out of DM&S and put it in construction.

Mr. DASCHLE. That's a strong word. You say it would be a disaster?

Mr. GAVAZZI. It will be, yes, sir.

If I were working as a medical center director, I would find my job very, very difficult.

Mr. DASCHLE. Mr. Brown?

Mr. BROWN. I take the same position, for two or three reasons.

I heard Mr. Turnage and his staff say that he had been to the field, where the chief engineer and the director said things were

fragmented and the responsibilities weren't too clear. That's absolutely true. But I don't know if the question was asked, "Would you support it being in construction service rather than in DM&S?" I think that's another question.

I pointed out earlier in my comments the real concern I have with the everyday maintenance and operation of a medical facility anywhere in the system. There are things that go wrong in those buildings every day during the week that you cannot wait for a piece of paper to cross Vermont Avenue to get the concurrence of the construction service to spend $100,000 to make things go. If I understand things correctly, the Chief Medical Director would have input. He would pass the paper over for concurrence of the Director of the Office of Facilities to expend $100,000 of nonrecurring maintenance and repair money, we now call it, which DM&S has control over. That's in the clinical care appropriation as well. I strongly agree.

Mr. DASCHLE. You heard General Turnage say that it was really an effort to consolidate the disparate organizational structure that exists today, that in an effort to streamline this process we spend a million bucks and Booz-Allen tells us that this is one of the ways you could overcome the difficulties and fragmentation. But you're saying that virtually every director out there, every center director, would oppose it.

How do you explain this incongruity here? You have a million dollar study which is in direct contrast to the views held by every center director.

Mr. BROWN. First of all, the Booz-Allen report on the area of engineering services did not recommend that go in the construction program. They took two or three people off the top of that in terms of specialty disciplines, but the everyday operational engineering staff in any of their recommendations was left as part of the Chief Medical Director's responsibility and accountability.

Mr. DASCHLE. So what you're saying is that General Turnage has overridden the very recommendation of the study?

Mr. BROWN. I am suggesting that his philosophy of management goes beyond what was recommended by the Booz-Allen and Hamilton report.

Mr. FALCO. What I see happening—and, I'm outside looking in—I think that when Mr. Walters saw the Booz-Allen report he had three recommendations. He said, "Well, why don't we just take all of construction and put it under the Chief Medical Director?" and, he did that. He may have had some good reason to do it. But the people that deliberated at Booz-Allen never expected that what we know as the construction service, developing working drawings and building buildings, would be under the Chief Medical Director. But the sense of putting it all together was that there could be economies.

The fact that the Chief Medical Director had the line authority over this process was the key to the decision because you needed a way to bring differences of opinion to resolution. So by having it all under the Chief Medical Director, it did, in fact, push it lower into the organization and there was a sense that the supervisory chain of command could bring to closure some of these long debates that take place in construction.

Mr. DASCHLE. So it is that line of authority that——

Mr. FALCO. I feel that that's the key to the decisionmaking process, and that's why I say you have to look at how you operate organizationally. We do not operate as a highly, centralized corporate headquarters organization. I think when the new Administrator came in, he said "Well, if it all has to be in one place, the Chief Medical Director is very busy, why don't we let that one place be somewhere else." That, I guess, makes a great deal of sense.

But I think you have to look at what the basic problems were relative to causing Booz-Allen to be hired. The line of authority in his decisionmaking process was really the key. It isn't so simple that you can say the hospital can decide what they need medically and then hand it over to a group of experts in building. The system doesn't work that easily. The construction development process requires an infinite number of decisions being made all the time. The problem that I see with the system is, because we are structured the way we are now, people don't compromise because the chain of command to bring to closure any honest difference of opinion happened at the Administrator's office. You don't get there very quickly to resolve problems.

So the major premise of the people working together was to push that decisionmaking further down into the organizational structure. I don't think anybody really thinks that the Chief Medical Director has to supervise the building of a building. I think there is a highly-technical and specialized group. But the early development of construction needs to be closer to the supervisory chain of command, to the user.

Unfortunately—and you people deal in construction—it isn't so simple as having a medical center saying "I need 120 nursing home care beds" and then pushing it into some organizational element to deliver them. It just doesn't work that way. Unfortunately, I get a kind of a sense that all this input across organizational lines works a lot easier than it does, in fact.

You see, I believe that the threat of a boss intervening causes people to compromise. So the lower in the organization you can make that threat occur, helps you stand a better chance of getting people to compromise. Many of the problems that we look at in construction today are because that last chain of command is the Administrator and he is not that accessible, and people tend to dig in and not compromise as much as they should. So pushing that kind of decisionmaking process deeper into the organization I think makes a great deal of sense.

But I also think that once the decisions are made early on, that work should be handed over to experts that know how to build buildings. So I see us here saying, you know, it's all this way or all that way. I'm not of that school of thought.

Mr. DASCHLE. Thank you, Mr. Falco.

We may have additional questions that we would like to submit to you for the record, to all of you. But you have certainly enlightened us this morning. We are grateful to you for your time and for your testimony and the expertise you have lent the committee in this regard.

Mr. Gavazzi, Mr. Falco, Mr. Brown, thank you.

Mr. BROWN. Thank you, sir.

Mr. GAVAZZI. I might add that I made a statement regarding Pennsylvania to the chairman who left, not for you, because I know you're from South Dakota.

Mr. DASCHLE. That's all right. I was beginning to think I was a household word in Pennsylvania.

[Laughter.]

Mr. DASCHLE. Our final panel is comprised of Mr. Dennis Cullinan, the assistant director of the Legislative Service of the VFW; Mr. Frank DeGeorge, the associate legislative director of the PVA, accompanied by Mr. Kim Beasley.

Mr. Cullinan, if you wish to proceed, your entire statement will be submitted for the record. You may proceed in any way you see fit.

STATEMENTS OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; FRANK DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY KIM BEASLEY, ASSOCIATE NATIONAL SERVICE DIRECTOR, PVA

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. I will present a brief synopsis of our written testimony.

I wish to thank you for this opportunity to present the views of the Veterans of Foreign Wars with respect to the announced plan to reorganize the VA construction planning and management processes.

An earlier consolidation plan offered by former Administrator Harry Walters encompassed transferring the Office of Construction to the Department of Medicine and Surgry, resulting in the Chief Medical Director having full accountability and responsibility for the agency's construction program.

At a recent hearing before the Senate Veterans' Affairs Committee, the VFW stated that, if properly conducted, bringing VA health care facility construction under the direct control of the CMD would provide for a more effective use of resources in delivering health care services and thereby increase overall VA effectiveness.

As is pointed out in the Booz-Allen and Hamilton study on the VA's method of constructing health care facilities, highly integrated efforts between health care program management and health care resources are required for the VA to effectively accomplish its mission.

For this reason, we support and continue to support bringing the VA construction program directly under the CMD's control. We are especially concerned that a proper balance be struck between program planning and facility planning, and this is why we believe it to be of critical importance that the CMD have primary responsibility for construction activities.

VA Administrator Thomas Turnage has now cancelled the planned consolidation of agency construction activities in DM&S and elected insteasd to create a separate, independent Office of Fa-

cilities out of OC and FEPAC that will report to him through the Associate Deputy Administrator for Logistics.

The VFW feels that it would be far more effective and efficient for the determination of medical needs, along with the concomitant construction plans and actions, to be consolidated under the Chief Medical Director. The CMD should have clear-cut resonsibility and accountability for the program since, in this way, he may continue to advocate for medical care needs and make sure that these considerations are taken wholly into account for construction planning.

Another concern is that the engineering services out from under the CMD will severely impair the day-to-day operation of VA medical centers. Engineering services clearly involves key operational functions in every medical center. It is, to our mind, imperative that operational services be resonsive to VAMC management needs. The VFW fears that this critical responsiveness would be undermined by the splitting of accountability between the new Office of Facilities and DM&S.

Mr. Chairman, we concur with Administrator Turnage that there is a need for a single organizational element within the VFA which is fully responsible and accountable for the management of agencies' capital facilities and real property programs. However, we quite disagree that this consolidated authority should be taken away from the CMD and established as an independent entity. It is a well known phenomenon that organizations tend to take on a life of their own. It is our concern that an independent Office of Facilities would eventually develop separate goals and priorities which could well be at times at odds with those of the VA health care system. The health care system's primary mission—delivering top quality health care to veterans—must not be subordinated to other goals.

Mr. Chairman, this concludes my testimony.

[Prepared statement of Dennis M. Cullinan appears at p. 111.]

Mr. DASCHLE. Thank you, Mr. Cullinan.

Mr. DeGeorge, I have a copy of your statement. Having had a chance to look it over, it is an extensive statement and obviously very well written. If you could summarize your statement, the entire text of it will be inserted for the record.

STATEMENT OF FRANK DE GEORGE

Mr. DEGEORGE. Thank you, Mr. Chairman. I will do so.

As stated earlier, Mr. Kim Beasley, our associate national service director, is accompanying me today.

The Paralyzed Veterans of America is most appreciative for you holding this most important hearing today, and it is a timely hearing, as stated earlier.

I would like to briefly state what is included in our testimony by reviewing some of the Booz-Allen study as follows:

The proposed reorganization of the Veterans' Administration's construction management and planning process is principally driven by the findings of the Booz-Allen and Hamilton/RTKL comprehensive study completed in April 1985. According to the study, the VA's facility planning activities in both DM&S and the Office

of Construction are seriously flawed. The study reveals that the current approach to prioritizing construction projects does not provide an adequate basis for resource allocation decisions. In addition, there is no clearly delineated national strategy or plan for meeting the combined construction needs of 172 VA medical centers.

The VA's annual 5-year medical facility construction needs assessment is not an assessment of need but, rather, an executive summary of requested major construction projects.

The VA's new prioritization methodology simply pioritizes construction requests, not necessarily overall construction needs. These 5-year facility plans are neither accurate, nor are they the product of a comprehensive planning process that would ensure viability, timeliness, or reasonable cost estimates.

VA medical centers currently do not have the capability, nor the resources, required to do the comprehensive facility planning. There is no logical system of well-defined activities for facility planning and project development. Facility planning is accomplished primarily by architectural firms in today's building design and construction industry. It cannot be assumed that current health care facility specialists in DM&S and Office of Construction are trained facility planners, capable of performing in this new role. Within these two organizational elements—FEPAC and the Health Care Facilities Service—there is a noticeable absence of architects and facility planning professionals. The VA simply has not kept abreast of current facility planning techniques nor the professional expertise necessary to perform the task.

PVA recognizes that these are strong criticisms regarding the VA's current facility planning program. Nevertheless, in light of current budgetary pressures to adopt efficient, underlined, operational practices, the Booz-Allen study upon which these criticisms are based is timely.

The Administrator of Veterans' Affairs, in a letter to the executive director of the Paralyzed Veterans of America, dated July 25, 1986, conveyed his plan to withdraw former Administrator Walters' proposal regarding the construction program. In PVA's view, the withdrawal of the first proposal does not constitute a radical policy change in the second. In fact, the similarities far outweigh the differences.

Specifically, both agree with the basic findings of the study. Both agree that it would be advantageous to designate a single source of accountability for the agency's construction program. Both agree that the implementation of the process changes will result in the best means to make major improvements in the timely and efficient delivery of health care construction.

The major difference is the organizational alignment of a consolidated facility planning and construction program. PVA supports General Turnage's decision to create an independent staff office for facility planning and construction. However, this organizational change alone will not ensure achievement of the critical process improvements.

The implementation of the core process recommendations deserve careful scrutiny because those organizational components who have allowed the process to become so flawed have now been

given the task of critiquing, interpreting and implementing those same recommendations. PVA wants to see not only timely implementation but proper implementation.

The proposed reorganization currently being considered fails to acknowledge the impact of the core process recommendations. There is an inherent danger in implementing a detailed reorganization plan around a seriously flawed process. The core process recommendations, which correct the serious procedural flaws, should be the basis of the proposed reorganization.

General Turnage states in his decision package that noticeable improvements have taken place in the construction program in the last 2 years. Among the improvements cited are prioritization methodology and, two, building prototypes. PVA has already testified as to the inadequacies of the new prioritization methodology. The agency's recent attempts at building prototypes have been a failure as evidenced by the nursing home care prototype. This notable initiative, which began in April 1983, sought to provide a prototypical building design resulting in quality, timely, cost-effective facilities to meet the long-term needs of our aging veterans.

However, 3 years later the VA Inspector General, in a report dated January 3, 1986, states that "The VA has not yet accomplished its major program initiative of developing a nursing home care prototype." He also states the "the planned reorganization of Office of Construction and DM&S will not ensure the resolution of these issues related to the nursing home care unit prototype." The Inspector General's recommendation was that "The VA should establish an appropriate design and approval process for assuring a cost-effective design of prototype nursing homes."

PVA's concern is that too much emphasis is being placed—again to repeat—on organizational structure and not enough emphasis given to critical process change.

VA medical centers have become dissatisfied with the current construction planning system that has grown less and less responsive to their needs. The process is lengthy, cumbersome, and inefficient in providing capital improvements to their physical plants. They are often left out of the key areas of project development. Properly implemented, the core process recommendations should correct this.

Unfortunately, delegation is seen by some as a solution to these problems. Delegation is in direct conflict with the Booz-Allen recommendations. By contrast, the Booz-Allen study conducted a comprehensive analysis which clearly defined procedural and organizational problems. An understanding of these problems became the basis for recommending a comprehensive solution.

The core process recommendations require that the Office of Facilities embrace an attitude more reflective of public servants who have a responsibility to 172 medical centers, to assess their facility needs and ensure that current state-of-the-art medical practices are accomplished.

VA facility planning, design and construction activity should be a direct response to medical program needs identified by DM&S. Removing facility planning activities from DM&S should not diminish the role of the CMD in determining medical program needs which drive the construction program. In a sense, it says medical

deals with medical and construction deals with construction, complementing each other in the need.

It is incumbent upon the new Office of Facilities to initiate proper procedures as identified in the Booz-Allen study that would ensure timely and appropriate responses to DM&S' medical program needs.

That concludes my statement, Mr. Chairman. I would also just add that we definitely would like to repeat our earlier statement, that we do appreciate the invitation to appear here today, and of the work of the committee and the oversight in looking at this current situation.

Thank you.

[Prepared statement of Frank DeGeorge appears at p. 116.]

Mr. DASCHLE. Thank you, Mr. DeGeorge, Mr. Cullinan. I appreciate your statements and we are grateful to you as well.

Were either of your organizations consulted during this planning process and prior to the time the reports were submitted?

Mr. DEGEORGE. It is my belief that our Executive Director was sent a presentation by General Turnage, yes, sir.

Mr. DASCHLE. You were sent a presentation. I'm not sure I understand.

Mr. BEASLEY. It was the briefing package.

Mr. DASCHLE. The briefing package. Were you invited to respond with specific recommendations?

Mr. DEGEORGE. It's my understanding that the answer to that is yes.

Mr. DASCHLE. Is that your understanding, Mr. Beasley?

Mr. Cullinan?

Mr. CULLINAN. Mr. Chairman, it is my understanding that we received a briefing package only last week. It was in the possession of the Director of our National Veterans Service. To my knowledge, there has been no exchange between the National Veterans Service nor the legislative arm, for which I work, with the Administrator on this issue. Certainly there has been nothing which would affirm his proposed reorganization.

Mr. BEASLEY. Yes. General Turnage did indicate at the end of his letter to the Executive Director of PVA that he welcomed discussion personally with him.

Mr. DASCHLE. When did you receive that?

Mr. DEGEORGE. I believe it was—It was dated July 25, the letter from the General, and I believe it was received on July 27.

Mr. DASCHLE. Received July 27.

Mr. DEGEORGE. Yes, sir.

Mr. DASCHLE. When was the decision by the VA Administrator made?

Mr. BEASLEY. That we don't know.

Mr. DEGEORGE. I have no knowledge of that, sir.

Mr. CULLINAN. Sir, we had the impression that it was a briefing package and, thus, addressed a decision. When exactly it would have been made, I don't know.

Mr. DASCHLE. As I understand it, the decision was made the week prior to that, Friday the 26th. You received your information on the 27th. So you, in essence, received——

Mr. DEGEORGE. By mail. Now, there might have been interchange by phone with the Executive Director or President of the PVA.

Mr. DASCHLE. I don't want to make a big thing of it. It just seems to me there is a difference between being briefed and being consulted. I think you all were briefed.

Mr. Rowland, do you have any questions or comments?

Mr. ROWLAND OF CONNECTICUT. No.

Mr. DASCHLE. We have some additional questions to submit for the record. I know the minority counsel has some.

Mr. Kingston SMITH. Mr. Chairman, we may submit a couple of questions.

Mr. DASCHLE. Without objection, we will have those submitted.

I also ask unanimous consent that the statement of Dr. Donald Custis, the former Chief Medical Director of the VA, be inserted in the record.

[Submitted statement of Dr. Donald Custis appears at p. 134.]

Mr. DASCHLE. Thank you very much, gentlemen, for your presentations, for your insight. We are very grateful to all of you.

Mr. DEGEORGE. Mr. Chairman, could I just add one comment before you close?

Mr. DASCHLE. Sure.

Mr. DEGEORGE. I would like to bring to your attention that the matter has been brought up to our board of directors while in convention this week in Memphis, Tennessee. They have agreed with the statement that has been presented here.

Mr. DASCHLE. Very good.

Mr. DEGEORGE. As well as the statement that was prepared for today's presentation was not delivered by one or two people. It was by a whole host of executives of the Paralyzed Veterans of America.

Mr. DASCHLE. Let the record so state that and show that. We assume, obviously, when you come before the committee, that you're not speaking for yourself, that you're speaking for the whole organization. It is the organization's views we seek. So we are grateful for that.

The hearing stands adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

APPENDIX

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN EDGAR TO VETERANS' ADMINISTRATION

STATEMENT OF THE HONORABLE ROBERT W. EDGAR

CHAIRMAN

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

AT HEARING CONCERNING

VA CONSTRUCTION ACTIVITIES REORGANIZATION

AUGUST 7, 1986

THE HEARING WILL COME TO ORDER.

I WISH TO WELCOME THE NEW ADMINISTRATOR OF VETERANS' AFFAIRS, MR. THOMAS TURNAGE. I MUST SAY, AND I AM CERTAIN I SPEAK FOR MY COLLEAGUES, THAT WE ARE PLEASED THAT HE CHOSE THIS HEARING FOR HIS FIRST APPEARANCE BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS. I AM CERTAIN THAT OUR MEMBERS LOOK FORWARD TO PERSONALLY ASKING HIM QUESTIONS ABOUT THE IMPORTANT ISSUE BEFORE US TODAY.

IT IS A GREAT UNDERSTATEMENT TO SAY THAT TODAY'S MEETING IS IMPORTANT. THE SUBJECT IS THE VA ADMINISTRATOR'S NEW ORGANIZATION TO PLAN AND EXECUTE FACILITY

IMPROVEMENTS AND CONSTRUCTION REQUIREMENTS OF THE DEPARTMENT OF MEDICINE AND SURGERY OF THE VETERANS' ADMINISTRATION. SO, LET US BE UPFRONT: THE SUBJECT TODAY IS THE DELIVERY OF MEDICAL CARE TO OUR NATION'S VETERANS.

WE ARE CONCERNED THAT THE ADMINISTRATOR'S CHANGE IN THE WAY CONSTRUCTION PROJECTS ARE PLANNED AND COMPLETED WOULD REMOVE THE AUTHORITY OF THE CHIEF MEDICAL DIRECTOR IN THESE MATTERS. WE ARE CONCERNED THAT THE ADMINISTRATOR'S PLAN REMOVES FROM THE CHIEF MEDICAL DIRECTOR EVEN THE STAFF ASSISTANCE TO WORK WITH CONSTRUCTION ISSUES. WE ARE CONCERNED THAT

THE ADMINISTRATOR'S PLAN REMOVES FROM THE CHIEF MEDICAL DIRECTOR THE DAY TO DAY MANAGEMENT OF OPERATIONAL REQUIREMENTS IN NONRECURRING MAINTENANCE AND REPAIR, AS WELL AS MINOR MISCELLANEOUS PROJECT PROGRAMS.

THE COMMITTEE HAS BEEN MADE AWARE ON SEVERAL OCCASIONS THAT THE CONSTRUCTION PROCESS AT THE VA HAD SOME PROBLEMS. WE HAVE HELD SEVERAL HEARINGS ON VARIOUS ASPECTS OF CONSTRUCTION. WE SUPPORTED THE IDEA OF THE CONTRACT, WHICH WAS LET TO BOOZ-ALLEN AND HAMILTON, FOR AN OUTSIDE CONSULTANT TO COME INTO THE VA, TO STUDY THE PROCESS, WRITE A REPORT AND MAKE RECOMMENDATIONS.

IT IS AN AMAZING REPORT WHEN YOU SEE THE DIVERGENCE OF THE TWO RESPONSES THAT WERE BASED ON IT. THE PREVIOUS ADMINISTRATOR PLANNED A REORGANIZATION BASED ON THE REPORT THAT WOULD HAVE PUT ALL OF THE CONSTRUCTION PROGRAM INTO THE DEPARTMENT OF MEDICINE AND SURGERY. THE NEW ADMINISTRATOR HAS A REORGANIZATION BASED ON THE REPORT THAT PULLS ALL OF CONSTRUCTION ACTIVITIES OUT OF THE DEPARTMENT OF MEDICINE AND SURGERY AND PUTS IT ALL INTO AN OFFICE OF FACILITIES. THOSE ARE TWO RADICALLY DIFFERENT PLANS BASED ON THE SAME REPORT. ONE WHICH RECOGNIZES THE CHIEF MEDICAL DIRECTOR'S RESPONSIBILITIES

MANDATED BY LAW AND THE OTHER WHICH IGNORES THOSE RESPONSIBILITIES.

WE HAVE READ THE BOOZ ALLEN, HAMILTON RECOMMENDATIONS AND WE ARE CONFUSED ABOUT THEM IN RELATION TO THE ADMINISTRATOR'S NEW ORGANIZATION PLAN THAT IS WHAT WE WANT TO EXPLORE TODAY.

OUR TASK IS COMPLICATED BY THE RECENT NEWS THAT DR. DITZLER HAS RESIGNED THE OFFICE OF CHIEF MEDICAL DIRECTOR AND WILL TAKE OVER THE DIRECTORSHIP OF THE VA MEDICAL CENTER IN SAN FRANCISCO. IT IS DISMAYING TO BE TOLD IN THE VA'S PRESS RELEASE THAT THE SITUATION AT ONE VA HOSPITAL WILL PRESENT A GREATER CHALLENGE FOR THE DIRECTOR THAN

RUNNING ALL 172 HOSPITALS IN THE VA SYSTEM. IN FACT, SUCH A STATEMENT STRAINS THE IMAGINATION OF THOSE WHO HAVE LONG WATCHED THE VA MEDICAL CARE SYSTEM. IT SEEMS MORE LIKELY THAT THE CONSTRUCTION REORGANIZATION WHICH TAKES FROM THE CHIEF MEDICAL DIRECTOR SOME OF THE MOST IMPORTANT TOOLS REQUIRED FOR HIM TO DO HIS STATUTORY JOB WAS TOTALLY UNACCEPTABLE TO DR. DITZLER.

CHANGES IN THE DELIVERY OF MEDICAL CARE MAKE MEDICAL CONSTRUCTION A PARAMOUNT CONCER FOR ANY CHIEF MEDICAL DIRECTOR. THE FINAL CONFIGURATION OF A FACILITY IS CRITICAL TO ITS FUTURE ABILITY TO DELIVER MEDICAL

SERVICES. IN ADDITION, THE DISRUPTION IN PATIENT CARE ACTIVITIES CAUSED BY CONSTRUCTION ACTIVITIES MUST BE TAKEN INTO ACCOUNT WHEN PLANNING AND EXECUTING CONSTRUCTION PROJECTS. WHEN THE CHIEF MEDICAL DIRECTOR HAS NO STAFF FOR THIS FUNCTION, HOW CAN HE DO HIS JOB?

THE AGE OF MANY OF THE VA'S MEDICAL FACILITIES MAKES BOTH MAJOR AND MINOR CONSTRUCTION A PARAMOUNT CONCERN FOR A CHIEF MEDICAL DIRECTOR. MAINTENANCE AND REPAIR FUNCTIONS CAN BE LIFE OR DEATH SITUATIONS AND, AS SUCH, MUST BE A TOP PRIORITY IN ORDER TO MAINTAIN DELIVERY OF HIGH QUALITY PATIENT CARE.

IT IS NO WONDER THAT A CHIEF MEDICAL DIRECTOR MIGHT THINK THE TOOLS HE NEEDS ARE BEING DENIED HIM BY THE CONSTRUCTION REORGANIZATION.

IN THE FINAL ANALYSIS IT IS MEMBERS OF THE CONGRESS WHO HAVE THE RESPONSIBILITY TO INSURE THAT HIGH QUALITY MEDICAL CARE IS DELIVERED TO OUR NATION'S VETERANS. AS PART OF THAT RESPONSIBILITY, WE ARE MEETING TODAY ON THE SUBJECT OF THE VA CONSTRUCTION PROCESS AND THE NEW REORGANIZATION.

I NOW TURN TO MY DISTINGUISHED COLLEAGUE, THE RANKING MINORITY MEMBER OF THIS SUBCOMMITTEE AND THE FULL COMMITTEE, FOR ANY REMARKS HE MAY WISH TO MAKE.

THE FIRST WITNESS IS THE ADMINISTRATOR OF VETERANS' AFFAIRS, MR. THOMAS TURNAGE. MR. ADMINSTRATOR, WELCOME.

STATEMENT

BY

HONORABLE THOMAS K. TURNAGE

ADMINISTRATOR

OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

AUGUST 7, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU THIS MORNING TO PRESENT TESTIMONY AND RESPOND TO QUESTIONS CONCERNING THE RECENTLY ANNOUNCED ORGANIZATIONAL AND PROCEDURAL IMPROVEMENTS IN THE VA'S CAPITAL FACILITIES PROGRAM. I ALSO ASK THAT THE JULY 25, 1986, DECISION MEMORANDUM AND RELATED SERIES OF QUESTIONS AND ANSWERS ON THE REALIGNMENT OF THE VA'S CAPITAL FACILITIES FUNCTIONS BE MADE PART OF THE RECORD.

AS YOU KNOW, THE VA'S CAPITAL FACILITIES PROGRAM IS A VERY SIGNIFICANT PROGRAM ACTIVITY FOR OUR AGENCY. THE VA OPERATES THE SECOND LARGEST CONSTRUCTION PROGRAM IN THE FEDERAL GOVERNMENT AND THE LARGEST MEDICAL FACILITY CONSTRUCTION PROGRAM IN THE NATION. IN THE LAST FOUR FISCAL

YEARS (FY 1983-FY 1986) THE VA HAS RECEIVED $3.2 BILLION IN SUPPORT OF OUR CONSTRUCTION AND PLANT MAINTENANCE NEEDS WHICH ENCOMPASSES A SYSTEM OF 172 MEDICAL CENTERS, 109 CEMETERIES, 131 NURSING HOMES AND DOMICILIARIES, 53 SATELLITE OUTPATIENT CLINICS, AND REGIONAL OFFICE COLOCATION PLANS. IN TERMS OF REAL PROPERTY, THE VA MANAGES APPROXIMATELY 5,000 BUILDINGS IN EXCESS OF 118 MILLION SQUARE FEET, 26,700 ACRES IN LAND HOLDINGS AND OVER 280 LEASES. CLEARLY, THE VA'S CAPITAL FACILITIES AND REAL PROPERTY HOLDINGS ARE CRITICAL FOR FULFILLING THE MISSION OF THIS AGENCY TO PROVIDE QUALITY SERVICE ON A TIMELY BASIS TO THIS NATION'S VETERANS. TO THE EXTENT WE CAN IMPROVE OUR MANAGEMENT OF THESE PROGRAM ACTIVITIES, WE MUST CONSTANTLY STRIVE TO DO SO.

SUCH AN EFFORT WAS UNDERTAKEN IN MARCH 1984 WHEN WE CONTRACTED WITH BOOZ, ALLEN AND HAMILTON, INC./RTKL ASSOCIATES, INC. TO CONDUCT A COMPREHENSIVE STUDY OF THE AGENCY'S ORGANIZATION AND PROCEDURES FOR CONSTRUCTING HEALTH CARE FACILITIES. THIS STUDY WAS UNDERTAKEN TO ADDRESS CONCERNS ABOUT ORGANIZATIONAL FRAGMENTATION AND DUPLICATION; TO CLARIFY ACCOUNTABILITY AND RESPONSIBILITY FOR VA HEALTH CARE FACILITY PLANNING, DESIGN AND CONSTRUCTION; TO IDENTIFY PROCEDURAL IMPROVEMENTS, INCLUDING THE NEED TO ENSURE RESPONSIVENESS TO OUR MEDICAL CENTER NEEDS; AND TO DETERMINE WAYS TO REDUCE THE DELIVERY TIME, IMPROVE THE QUALITY AND ENSURE THE COST EFFECTIVENESS OF VA FACILITY CONSTRUCTION. THE FINAL REPORT, ISSUED IN APRIL 1985, CONTAINS TWO PRIMARY FINDINGS. THE FIRST AND MOST IMPORTANT FINDING IS THAT THE VA'S CURRENT HEALTH CARE FACILITY POLICIES AND PROCEDURES, PRINCIPALLY IN THE AREA OF PROGRAM AND PROJECT PLANNING, NEED

TO BE IMPROVED. SECOND, THE VA'S INTEGRATION AND COORDINATION OF ITS HEALTH CARE FACILITIES CONSTRUCTION PROGRAM ARE HINDERED BY THE CURRENT FRAGMENTATION OF RESPONSIBILITIES BETWEEN THE DEPARTMENT OF MEDICINE AND SURGERY (DM&S) AND THE OFFICE OF CONSTRUCTION (O/C) TO THE DEGREE THAT THERE IS NO SINGLE ACCOUNTABLE OR RESPONSIBLE ENTITY BELOW THE LEVEL OF THE ADMINISTRATOR FOR THE AGENCY'S CAPITAL FACILITIES PROGRAM. THE BOOZ, ALLEN/RTKL STUDY FURTHER FOUND MANY STRENGTHS IN THE VA'S CURRENT HEALTH CARE FACILITY CONSTRUCTION PROGRAM WHICH PROVIDE A SOLID FOUNDATION UPON WHICH FURTHER IMPROVEMENTS CAN BE MADE.

WITH RESPECT TO THE ORGANIZATIONAL PROBLEMS IDENTIFIED, THE BOOZ, ALLEN/RTKL REPORT OFFERED THREE ORGANIZATIONAL OPTIONS WHICH WERE DESIGNED TO REDUCE OR ELIMINATE, IN VARYING DEGREES, ORGANIZATIONAL DEFICIENCIES THAT THE CONSULTANTS CONCLUDED HAVE RESULTED IN FRAGMENTATION, DUPLICATION, CONFUSION OF ROLES AND RESPONSIBILITIES, AND ABSENCE OF CLEAR LINES OF ACCOUNTABILITY. DURING THE AGENCY'S REVIEW OF THESE OPTIONS, THERE WAS UNANIMOUS AGREEMENT THAT THE OPTIONS SHOULD BE TAKEN FURTHER, AND THAT HEALTH CARE AND OTHER (CEMETERY, REGIONAL OFFICE) FACILITY PLANNING, DESIGN AND CONSTRUCTION AND REAL PROPERTY FUNCTIONS SHOULD BE WHOLLY INTEGRATED AND CONSOLIDATED IN ONE ORGANIZATION.

AS YOU KNOW, ON OCTOBER 31, 1985, THE FORMER ADMINISTRATOR OF VETERANS AFFAIRS ANNOUNCED HIS INTENTION TO TRANSFER THE OFFICE OF CONSTRUCTION AS A UNIT TO THE DEPARTMENT OF MEDICINE AND SURGERY, BASED IN PART ON THE FINDINGS AND RECOMMENDATIONS OF THE BOOZ, ALLEN/RTKL STUDY. SUBSEQUENTLY, ON FEBRUARY 5, 1986, THE THEN ACTING ADMINISTRATOR OF

VETERANS AFFAIRS SUBMITTED PROPOSED LEGISLATION TO WAIVE THE REQUIREMENTS OF 38 U.S.C. SECTION 210(b)(2) TO PERMIT THIS REORGANIZATION TO BE EFFECTED. ON MARCH 24, 1986, I WAS CONFIRMED AS THE NEW ADMINISTRATOR OF VETERANS AFFAIRS, AND BY LETTER OF APRIL 2, 1986, TO THE HOUSE VETERANS AFFAIRS COMMITTEE, ASKED THAT SCHEDULED HEARINGS ON THE PROPOSED REORGANIZATION BE POSTPONED IN ORDER TO PERMIT MY REVIEW OF THE PROPOSED ORGANIZATIONAL CHANGE. I COMPLETED THAT REVIEW AND ON JUNE 3 AND AGAIN ON JUNE 25 DRAFTS OF MY DECISION WERE STAFFED FOR AGENCY COMMENT. ON JULY 13, 1986, A DRAFT COPY OF MY FINDINGS, CONCLUSIONS AND DECISION ALSO WAS PROVIDED TO THIS COMMITTEE. ON JULY 17, MY CHIEF OF STAFF THEN BRIEFED COMMITTEE STAFF ON THE DRAFT DECISION MEMORANDUM WHICH WAS SUBSEQUENTLY ISSUED IN FINAL ON JULY 25. A SECOND BRIEFING WAS HELD ON JULY 25 TO FURTHER EXPLAIN AND RESPOND TO COMMITTEE STAFF QUESTIONS ON MY DECISION.

REVIEW OF THE BOOZ, ALLEN/RTKL STUDY AND DISCUSSIONS WITH OFFICIALS IN THE VA'S DEPARTMENT OF MEDICINE AND SURGERY, OFFICE OF CONSTRUCTION AND OTHER VA OFFICES LED ME TO TWO PRIMARY CONCLUSIONS: FIRST, THAT THE AGENCY NEEDS TO MOVE FORWARD IMMEDIATELY TO IMPLEMENT THE MANY SIGNIFICANT PROCEDURAL IMPROVEMENTS ("CORE PROCESS RECOMMENDATIONS") RECOMMENDED IN THE BOOZ, ALLEN/RTKL STUDY. SECOND, THAT, AS REFLECTED IN THE PREVIOUS ADMINISTRATOR'S PROPOSAL, THERE MUST BE A SINGLE ORGANIZATIONAL ELEMENT WITHIN THE VA WHICH IS FULLY RESPONSIBLE AND ACCOUNTABLE FOR THE INTEGRATED MANAGEMENT OF THE AGENCY'S CAPITAL FACILITIES AND REAL PROPERTY PROGRAMS. HOWEVER, THAT REVIEW ALSO

CONVINCED ME THAT THE OVERALL NEEDS OF THE VA WILL BEST BE SERVED IF THE AGENCY'S CAPITAL FACILITIES AND REAL PROPERTY PROGRAMS ARE RETAINED AND CONSOLIDATED IN AN INDEPENDENT STAFF OFFICE FUNCTION. THAT APPROACH IS CONSISTENT WITH THE PREVIOUS REORGANIZATION PROPOSAL TO CONSOLIDATE THE FUNCTIONS OF THE FACILITIES ENGINEERING, PLANNING AND CONSTRUCTION (FEPAC) OFFICE IN DM&S AND THE OFFICE OF CONSTRUCTION INTO ONE UNIT. THE REVIEW ALSO LED ME TO THE CONCLUSION THAT PLACING THE AGENCY'S CAPITAL FACILITIES PROGRAM IN DM&S, AS PREVIOUSLY PROPOSED, HAD SEVERAL POTENTIAL PROBLEMS. FIRST AND FOREMOST, THE MISSION OF DM&S IS QUALITY PATIENT CARE, INCLUDING AN ACTIVE PROGRAM OF MEDICAL EDUCATION AND RESEARCH AND MEDICAL BACKUP TO THE DEPARTMENT OF DEFENSE. TO POTENTIALLY DIMINISH IN ANY WAY THE CHIEF MEDICAL DIRECTOR'S AND THE DEPARTMENT'S ABILITY TO ATTEND TO THIS CRITICAL MISSION, PARTICULARLY IN THIS COMPLEX PERIOD IN VA HEALTH CARE PLANNING, WOULD BE MOST UNFORTUNATE. SIMILARLY, THE SIZE, COMPLEXITY AND RESOURCE REQUIREMENTS OF THE VA'S CONSTRUCTION PROGRAM AND REAL PROPERTY HOLDINGS REQUIRE SIGNIFICANT MANAGEMENT ATTENTION. EFFECTIVE AND EFFICIENT IMPLEMENTATION OF THE IMPROVEMENTS IN THESE PROGRAMS RECOMMENDED IN THE BOOZ, ALLEN/RTKL STUDY WOULD ADD TO THESE MANAGEMENT RESPONSIBILITIES. TO PLACE THESE RESPONSIBILITIES ON DM&S AND THE CHIEF MEDICAL DIRECTOR WOULD DIVERT ATTENTION AWAY FROM THE DEPARTMENT'S PRIMARY HEALTH CARE MISSION AND IS NOT APPROPRIATE. SECOND,THE VA'S FACILITIES PROGRAM PROVIDES LEASING, WORK SPACE MANAGEMENT, REAL PROPERTY MANAGEMENT, AND PLANNING, DESIGN AND CONSTRUCTION SUPPORT TO ALL THREE VA DEPARTMENTS AND SEVERAL VA STAFF OFFICES. IN THE YEARS AHEAD, I ANTICIPATE AN ACTIVE COLOCATION PROGRAM

FOR DVB'S REGIONAL OFFICES WHERE SUCH PROJECTS ARE COST EFFECTIVE, AND CONTINUED EXPANSION OF BURIAL SITES AT EXISTING NATIONAL CEMETERIES. THESE PROGRAMS AND THEIR RESOURCE NEEDS CAN BEST BE SUPPORTED BY AN INDEPENDENT FACILITIES OFFICE WHOSE PRIMARY MISSION IS TO SERVE THE NEEDS OF ALL VA ELEMENTS RATHER THAN TO BE A SECONDARY MISSION OF ONE OF THE VA'S DEPARTMENTS. FINALLY, THERE IS THE ISSUE OF PROGRAM OVERSIGHT. RETENTION OF AN INDEPENDENT FACILITIES OFFICE DIRECTLY RESPONSIBLE AND ACCOUNTABLE FOR THE SOLE FUNCTION OF MEETING THE CAPITAL FACILITIES AND REAL PROPERTY NEEDS OF ALL ELEMENTS OF THIS AGENCY PRESERVES AND MAINTAINS CRITICALLY NEEDED PROGRAM OVERSIGHT AND CONTROL OF THESE PROGRAMS MORE THAN ANY OTHER ORGANIZATIONAL ALTERNATIVE. ON THE OTHER HAND, FROM A PURELY MANAGEMENT PERSPECTIVE, PLACEMENT OF THESE RESPONSIBILITIES IN ONE USER DEPARTMENT IS INHERENTLY IMBALANCED AND CREATES THE NEED TO ESTABLISH NEW INDEPENDENT OVERSIGHT ELEMENTS IN OTHER VA ORGANIZATIONS WHOSE ABILITY TO ACCOMPLISH SUCH OVERSIGHT EFFECTIVELY IS PROBLEMATIC.

THEREFORE, MY JULY 25, 1986, DECISION MEMORANDUM RETAINS THE AGENCY'S CAPITAL FACILITIES PROGRAM IN AN INDEPENDENT STAFF OFFICE FUNCTION BY TRANSFERRING 64 OF THE 73 FEPAC FTEE CEILING FROM DM&S TO THE OFFICE OF CONSTRUCTION, ALONG WITH SUPPORTING RESOURCES. AS THE PROVISIONS OF 38 U.S.C. SECTION 210(b)(2) DO NOT APPLY TO THIS REALIGNMENT, THE AGENCY'S PREVIOUS LEGISLATIVE PROPOSAL TO WAIVE THE REQUIREMENTS OF 38 U.S.C. SECTION 210(b)(2) REGARDING THE FORMER ADMINISTRATOR'S PROPOSED REORGANIZATION HAS BEEN WITHDRAWN. ON JULY 31, 1986, THE 64 FEPAC FTEE WERE DETAILED TO THE OFFICE OF CONSTRUCTION (O/C) ON AN INTERIM BASIS TO

FACILITATE THE TRANSITION. THE VA'S CHIEF MEDICAL DIRECTOR, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS, AND DIRECTOR, OFFICE OF CONSTRUCTION ARE GUIDING THE TRANSITION EFFORT. ON AUGUST 15, THE CHIEF MEDICAL DIRECTOR AND THE DIRECTOR, OFFICE OF CONSTRUCTION, ARE TO SUBMIT A DETAILED REALIGNMENT AND ACTION PLAN FOR THE PERMANENT ORGANIZATIONAL INTEGRATION OF THE AFFECTED FEPAC ELEMENTS INTO O/C EFFECTIVE OCTOBER 1, 1986. ALSO EFFECTIVE OCTOBER 1, THE NEWLY COMBINED FEPAC AND O/C OFFICES WILL BE RENAMED THE OFFICE OF FACILITIES TO BETTER REFLECT ITS RESPONSIBILITIES FOR OVERALL MANAGEMENT OF AN INTEGRATED CAPITAL FACILITIES PROGRAM, INCLUDING REAL PROPERTY MANAGEMENT, SPACE MANAGEMENT, OVERALL FACILITY PLANNING, AND PROJECT PLANNING, DESIGN AND CONSTRUCTION ACTIVITIES. IN FY 1987, THE OFFICE OF FACILITIES WILL HAVE A TOTAL FTEE CEILING OF 734. THIS CEILING PROVIDES FOR AN IMMEDIATE REDUCTION OF 28 FTEE TO REFLECT FY 1987 CONSOLIDATION EFFICIENCIES OVER FY 1986 O/C AND FEPAC LEVELS (-54 FTEE IF YOU USE O/C's ORIGINAL CONGRESSIONALLY APPROVED FY 1986 CEILING OF 710).

THE ESTABLISHMENT OF AN INTEGRATED CAPITAL FACILITIES STAFF OFFICE FUNCTION IN THE VA WILL CREATE A UNIFIED SYSTEM FOR THE AGENCY'S CAPITAL FACILITIES AND REAL PROPERTY PROGRAMS AND ESTABLISH A SINGLE FOCUS OF MANAGEMENT RESPONSIBILITY AND ACCOUNTABILITY. THE NEW OFFICE OF FACILITIES WILL BE CHARGED WITH EFFECTIVELY AND EFFICIENTLY MEETING THE FACILITY NEEDS OF DM&S, THE DEPARTMENT OF VETERANS BENEFITS, THE DEPARTMENT OF MEMORIAL AFFAIRS AND THE VA STAFF OFFICES IN A MANNER WHICH REFLECTS THE PROGRAM NEEDS AND PRIORITIES OF THOSE ENTITIES.

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ONE ISSUE WHICH POSSIBLY HAS BEEN MISUNDERSTOOD IN THIS REALIGNMENT PERTAINS TO THE TRANSFER OF FEPAC'S CENTRAL OFFICE ENGINEERING SERVICE TO THE OFFICE OF FACILITIES. THE CONCERN HAS BEEN EXPRESSED THAT THIS MOVE WILL IN SOME MANNER HINDER THE ABILITY OF MEDICAL CENTERS TO MANAGE DAY-TO-DAY OPERATIONAL REQUIREMENTS. I WISH TO EMPHASIZE THAT THE REALIGNMENT WILL IN NO WAY UNDERMINE OR HINDER THE ABILITY OF OUR MEDICAL CENTER DIRECTORS TO PERFORM THEIR JOB. INDEED, WITH THE ENHANCED PARTICIPATION OF THE MEDICAL CENTERS IN CONSTRUCTION PLANNING, THE STREAMLINING OF THE PROCESS, AND THE ELIMINATION OF CENTRAL OFFICE ORGANIZATIONAL REDUNDANCIES, WE ENVISION THE CAPITAL FACILITIES SUPPORT AND SERVICE TO OUR MEDICAL CENTERS WILL IMPROVE MEASURABLY. FIELD ENGINEERS, AS DM&S EMPLOYEES, WILL CONTINUE TO MANAGE RECURRING MAINTENANCE AND REPAIR PROGRAMS AND DAY-TO-DAY OPERATIONAL NEEDS AS THEY ALWAYS HAVE. THE PURPOSE OF TRANSFERRING THE CENTRAL OFFICE ENGINEERING SERVICE STAFF TO THE NEW OFFICE OF FACILITIES IS TO PROVIDE A TOTALLY INTEGRATED CAPITAL FACILITIES PROGRAM WHICH INCLUDES THE MAJOR, MINOR, MINOR MISCELLANEOUS, AND NONRECURRING MAINTENANCE AND REPAIR (NRM) CONSTRUCTION PROGRAMS, AS WELL AS REAL PROPERTY PROGRAMS.

I ALSO WISH TO EMPHASIZE THAT THIS REALIGNMENT IN NO MANNER UNDERMINES THE CHIEF MEDICAL DIRECTOR'S AUTHORITIES OR ABILITY TO FULFILL HIS MISSION. THE OFFICE OF FACILITIES IS A SERVICE ORGANIZATION WHOSE FUNCTION AND RESPONSIBILITY ARE TO MEET THE FACILITY NEEDS OF DM&S AS IDENTIFIED AND PRIORITIZED BY THE CHIEF MEDICAL DIRECTOR (CMD). THE CMD, AND THE OTHER DEPARTMENT AND STAFF OFFICE HEADS, ARE FULLY RESPONSIBLE

FOR PROGRAM PLANNING AND PRIORITIZATION OF NEEDS. OFFICE OF FACILITIES IS CHARGED WITH MEETING THOSE NEEDS IN SUPPORT OF THE STATUTORY AUTHORITIES AND RESPONSIBILITIES ASSIGNED TO THE ADMINISTRATOR IN 38 U.S.C. 5001-5007.

AS NOTED EARLIER IN THIS TESTIMONY, IN THE JULY 25, 1986, DECISION MEMORANDUM, I PLACED EMPHASIS ON MOVING FORWARD WITH IMMEDIATE IMPLEMENTATION OF THE PROCEDURAL IMPROVEMENTS RECOMMENDED IN THE BOOZ, ALLEN/RTKL STUDY. ESTABLISHMENT OF AN INTEGRATED CAPITAL FACILITIES ORGANIZATION WILL FACILITATE ACHIEVEMENT OF THESE PROCESS IMPROVEMENTS. HOWEVER, THE SUBSTANCE OF IMPROVEMENTS IN OUR CONSTRUCTION PROGRAM WILL COME FROM THE ACTUAL IMPLEMENTATION OF THE "CORE PROCESS RECOMMENDATIONS" SET FORTH IN THE BOOZ, ALLEN/RTKL STUDY AND ONLY TO A LESSER EXTENT BY ORGANIZATIONAL REALIGNMENTS. I HAVE EXPRESSED CONCERN THAT IN THE 15 MONTHS SINCE COMPLETION OF THIS COMPREHENSIVE STUDY MORE FOCUS HAS BEEN PLACED ON ORGANIZATIONAL ISSUES AND LESS ON THE SUBSTANTIVE PROCEDURAL IMPROVEMENTS. TO ENSURE EFFECTIVE IMPLEMENTATION OF THESE PROCEDURAL IMPROVEMENTS, ON MAY 19, 1986, I DIRECTED THAT AN IMPLEMENTATION PLAN FOR THE "CORE PROCESS RECOMMENDATIONS" BE DEVELOPED AND INTEGRATED INTO AN ACTION PLAN FOR FY 1986 AND THE OUTYEARS.

THE BOOZ, ALLEN AND HAMILTON/RTKL REPORT PRESENTED SEVEN BROADLY BASED CORE PROCESS RECOMMENDATIONS THAT FOCUSED PRIMARILY ON NEEDED IMPROVEMENTS IN CONSTRUCTION PLANNING. THESE SEVEN "CORE PROCESS RECOMMENDATIONS" ARE AS FOLLOWS:

(1) IMPLEMENT AN OVERALL FACILITY DEVELOPMENT APPROACH TO CONSTRUCTION

- o PREPARE FACILITY DEVELOPMENT PLANS (FDP) FOR ALL VAMCS THAT IDENTIFY A PREFERRED FACILITY DEVELOPMENT APPROACH BASED ON A CONSIDERATION OF CURRENT FACILITY CAPABILITIES AND FUTURE REQUIREMENTS.

- o MAINTAIN STATISTICAL DATA REQUIRED TO DEVELOP THE FACILITY DEVELOPMENT PLAN IN AN AUTOMATED DATA BASE TO IMPROVE FDP UPDATING CAPABILITIES.

(2) EMPHASIZE EARLIER DEFINITION OF DESIGN PROBLEMS AND CONSTRAINTS IN PROJECT PLANNING

- o FOR ALL CONSTRUCTION PROJECTS, DEVELOP DESIGN PROGRAMS THAT DEFINE THE DESIGN PROBLEMS AND CONSTRAINTS.

- o DEVELOP INITIAL DESIGN PROGRAMS PRIOR TO INCLUSION OF PROJECTS IN THE 5-YEAR FACILITY CONSTRUCTION PLAN; DEVELOP FINAL DESIGN PROGRAMS JUST PRIOR TO DESIGN.

- o DEVELOP FORMAL PROJECT MANAGEMENT PLANS THAT IDENTIFY THE METHOD OF ACCOMPLISHMENT, SUPPORT REQUIREMENTS, AND PROJECT SCHEDULE FOR ALL PROJECTS PROPOSED IN 5-YEAR FACILITY CONSTRUCTION PLANS.

(3) COORDINATE CONSTRUCTION PROGRAM PLANNING MORE CLOSELY WITH MEDICAL PROGRAM PLANNING

- o DEVELOP A COMMON SUBMISSION CYCLE FOR ALL 5-YEAR FACILITY CONSTRUCTION PLANS.

- o ESTABLISH NATIONAL CONSTRUCTION PROGRAM PLANNING GUIDANCE BASED ON THE SCOPE AND DIRECTION OF MEDICAL PROGRAM INITIATIVES.

- o DEVELOP 5-YEAR FACILITY PLANS IMMEDIATELY FOLLOWING MEDIPP APPROVAL TO IMPLEMENT APPROVED ACTIONS IN MEDIPP PLANS.

(4) DEVELOP BETTER INFORMATION ON CONSTRUCTION NEEDS TO GUIDE CONSTRUCTION PROGRAM RESOURCE ALLOCATION DECISIONS

- o DEVELOP A PLANNING DATA BASE UTILIZING STATISTICAL INFORMATION FROM FACILITY DEVELOPMENT PLANS TO DETERMINE OVERALL DEFICIENCIES AT THE VAMC, DISTRICT, AND NATIONAL OFFICE LEVELS.

- o DEFINE AND CLASSIFY PROJECT DURING PLANNING ACTIVITIES BY CONSTRUCTION-RELATED OBJECTIVES (MAINTENANCE, UPGRADE, NEW CAPABILITIES) TO PROVIDE A STRATEGIC BASIS FOR RESOURCE ALLOCATION.

(5) STRUCTURE DESIGN ACTIVITIES TO RESOLVE FUNCTIONAL AND SCOPE ISSUES EARLIER IN THE DESIGN PROCESS

- o COMPLETE SCHEMATIC DESIGN AS THE INITIAL STEP IN THE DESIGN PROCESS TO RESOLVE FUNCTIONAL AND SCOPE ISSUES.

- o DEVELOP PRELIMINARY DESIGN TO A POINT WHERE ALL FUNCTIONAL ISSUES HAVE BEEN RESOLVED.

- o REDUCE EFFORT DEVOTED TO DESIGN REVIEWS BY REDUCING THE NUMBER OF REVIEWS DURING THE DEVELOPMENT OF CONSTRUCTION DOCUMENTS.

(6) DEVELOP FUNDING STRATEGIES THAT MINIMIZE COORDINATION REQUIREMENTS BETWEEN THE CONSTRUCTION PROCESS AND THE BUDGET PROCESS

- o DEVELOP A MAJOR CONSTRUCTION FUNDING APPROACH THAT ALLOWS UNINTERRUPTED DESIGN FROM SCHEMATICS THROUGH COMPLETION OF CONSTRUCTION DOCUMENTS.

- o CONSIDER ELIMINATION OF THE MINOR CONSTRUCTION "APF FUND" ONCE PLANNING RECOMMENDATIONS ARE IMPLEMENTED.

(7) IMPROVE PROCESS-LEVEL STANDARDS AND CONTROL TOOLS

- o EXPLICITLY IDENTIFY OPERATING ASSUMPTIONS IMPLICIT IN CURRENT SPACE AND FUNCTIONAL CRITERIA AND UPDATE STANDARDS THAT ARE OBSOLETE.

- DEFINE THE WAY SERVICES ARE PROVIDED BY VAMCS FOR FUNCTIONS THAT ARE AMENABLE TO STANDARDIZATION AND IDENTIFY MAJOR VARIATIONS.

TO THESE SEVEN RECOMMENDATIONS, WE HAVE ADDED AN EIGHTH RECOMMENDATION WHICH IS TO REVALIDATE MEDICAL PROGRAM PLANNING DATA AT CRITICAL MILESTONES THROUGHOUT PROJECT DEVELOPMENT.

IN RECENT YEARS, THE VA HAS UNDERTAKEN A NUMBER OF INITIATIVES WHICH HAVE IMPROVED ITS FACILITY PLANNING AND CONSTRUCTION PROGRAM. THESE INCLUDE MEDIPP; INITIATION OF THE ADVANCE PLANNING FUND, THE ADVANCE PLANNING APPROACH IN THE MINOR CONSTRUCTION PROGRAM, A COMPREHENSIVE ASSESSMENT OF OUR MEDICAL CENTERS USING AN AUTOMATED DATA BASE APPROACH, AUTOMATION ENHANCEMENTS OF TECHNICAL AND MANAGEMENT INFORMATION NEEDS, THE DESIGN FUND, PROTOTYPING, COMPUTER AIDED DESIGN APPLICATIONS; DEVELOPMENT OF NEW LEASING PROCEDURES; DELEGATION OF APPROVAL AUTHORITIES; COMPARISON OF OUR STANDARDS AND SPECIFICATIONS WITH THE PRIVATE SECTOR; DEVELOPMENT OF A MORE QUANTIFIABLE CONSTRUCTION PROJECT PRIORITIZATION METHODOLOGY; FORMALIZATION OF MEDICAL CENTER (USER) PARTICIPATION IN ALL ASPECTS OF PROJECT PLANNING AND DESIGN; AND EXPANDED USE OF PHASED CONSTRUCTION AND CRITICAL PATH METHOD.

THE BOOZ, ALLEN/RTKL RECOMMENDATIONS WILL BUILD SUBSTANTIVELY ON THESE PREVIOUS INITIATIVES AND WE LOOK FORWARD WITH ENTHUSIASM TO THE MANY ADDITIONAL AND SIGNIFICANT IMPROVEMENTS THEIR IMPLEMENTATION WILL EFFECT. IN PARTICULAR, WE BELIEVE THAT ACCOMPLISHMENT OF FACILITY DEVELOPMENT PLANS (FDP) FOR EACH OF OUR MEDICAL CENTERS WILL GREATLY

ENHANCE OUR ABILITY TO ACCOMPLISH A NATIONWIDE CONSTRUCTION PLANNING STRATEGY BASED ON A COMPREHENSIVE ASSESSMENT OF EACH FACILITY'S NEEDS, WHICH WILL BE REVALIDATED ANNUALLY. WE ARE CURRENTLY REVIEWING A PLAN TO PILOT TEST THE FDP APPROACH AT FOUR MEDICAL CENTERS PRIOR TO OUR CONTRACTING FOR THE FIRST 40 FDPS IN FY 1987. TO HELP SUPPORT THIS EFFORT, WE ALSO RECENTLY CONTRACTED FOR DEVELOPMENT OF AN AUTOMATED INTERACTIVE MEDICAL FACILITIES PLANNING SYSTEM WHICH WILL UPGRADE OUR SPACE PLANNING ACTIVITIES USING STATE OF THE ART COMPUTER TECHNOLOGY. THE SYSTEM WILL PROVIDE FLEXIBILITY IN THE PLANNING AND ANALYSIS OF SPACE REQUIREMENTS. WE EXPECT THIS NEW SOFTWARE PACKAGE TO BE AVAILABLE FOR OUR USE IN LATE FALL.

AS WE MOVE FORWARD WITH IMPLEMENTATION OF THE BOOZ, ALLEN/RTKL CORE PROCESS RECOMMENDATIONS AND OUR NEW ORGANIZATIONAL ALIGNMENT, WE WOULD WELCOME THE OPPORTUNITY TO PERIODICALLY BRIEF YOU OR YOUR STAFF ON OUR NEW PROCESSES AND PROCEDURES. WE BELIEVE OUR PLANNED ORGANIZATIONAL AND PROCEDURAL INITIATIVES WILL RESULT IN MEASURABLE IMPROVEMENTS IN THE PLANNING, DESIGN AND CONSTRUCTION OF VA FACILITIES AND WE LOOK FORWARD TO OUR FIRST YEAR OF IMPLEMENTATION.

Veterans Administration

Memorandum

Date July 25, 1986

From Administrator (00)

Subj Organizational and Procedural Improvements in the VA's Construction Program

To Department Heads, Associate Deputy Administrators, Staff Office Directors, and all Field Stations

1. As you know, on October 31, 1985, my predecessor as Administrator of Veterans Affairs announced his intention to transfer the Office of Construction as a unit to the Department of Medicine and Surgery. This proposal was based in part on the findings and recommendations of the "Comprehensive Study of the Veterans Administration's Organization and Procedures for Constructing Health Care Facilities" (Booz, Allen & Hamilton/RTKL Associates-April 1985).

2. Since I was confirmed as Administrator, one of my first priorities has been to thoroughly review this very significant reorganization proposal. To assist in this assessment, I have reviewed available information and documents related to the proposed reorganization, including the Booz, Allen/RTKL study, and drawn on the collective expertise of officials within the Department of Medicine and Surgery, the Office of Construction, and others. My review is now completed, and this memorandum sets forth my decisions.

3. The Booz, Allen/RTKL study contains two primary findings. The first and most important finding is that the VA's current health care facility construction policies and procedures, principally in the area of program and project planning, need to be improved. Second, the VA's integration and coordination of its health care facilities construction program is hindered by the current fragmentation of responsibilities between the Department of Medicine and Surgery (DM&S) and the Office of Construction (O/C). The Booz, Allen/RTKL study further found that the VA's current health care facility construction process has a number of strengths which provide a good foundation upon which further improvements can be made. Based on my own observations, as well as my review of the program, I agree with these basic findings.

4. The VA's facility construction program, the second largest in the Federal Government, is critical to fulfilling the mission of this Agency to provide quality service on a timely basis to this nation's veterans. These facilities and real property holdings are capital investments which we improve and maintain to support the effective delivery of our services. To the extent that we can improve our management of these capital assets, we must take immediate action to do so and constantly assess our procedures and practices to strive for even better performance. Although the Booz, Allen/RTKL study only focused on one important part of the Agency's capital facilities program--the health care facility construction process--it contains a number of important

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Department Heads, Associate Deputy Administrators, Staff Office Directors, and all Field Stations

recommendations which I believe will be of benefit to our entire capital facilities program. In their assessment of our current program, the Booz, Allen/RTKL report, in particular, recommended many significant procedural improvements ("core process recommendations") which could be made in our current construction procedures. We need to immediately move forward in our implementation of these procedural efficiencies. Effective May 19, 1986, I assigned responsibility to the Associate Deputy Administrator for Logistics to develop an implementation plan for these core process recommendations and to integrate required actions into a plan for FY 1986 and the outyears. Through our implementation of these core process recommendations, I look forward to seeing measurable improvements in the procedures by which we plan, design and construct our capital improvements.

5. With respect to the organizational problems identified, the Booz, Allen/RTKL report offered three organizational options which would have transferred and consolidated various responsibilities within and between DM&S and O/C. During the Agency review of these options, there was unanimous agreement that the options should be taken further, and that health care and other (DVB, DMA) facility planning, design, construction and real property functions should be wholly integrated and consolidated in one organization. I agree with this assessment. Under the current organization, or indeed any organizational alignment which still divides responsibilities, it is extremely difficult to hold a specific organizational element responsible for performance. I, therefore, strongly believe that there must be a single organizational element fully responsible and accountable for all facility matters, including the integrated management of the VA's facilities planning, design, construction and real property programs. I also strongly believe that establishment now of that single point of accountability will facilitate my ability, as Administrator, to ensure achievement of the critical process improvements which must be made in our planning, design and construction of VA facilities.

6. My review, however, also has convinced me that the overall needs of the VA will best be served if the Agency's capital facilities and real property programs are consolidated in an independent staff office function. Placing the construction program within the Department of Medicine and Surgery, as previously proposed, raises several potential problems. First and foremost, the mission of DM&S is quality patient care, including an active program of medical education and research and medical backup to the Department of Defense. To potentially diminish in any way the Chief Medical Director's and the Department's ability to attend to this critical mission, particularly in this complex period in VA health care planning, would be most unfortunate. Similarly, the size,

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complexity and resource requirements of the VA's construction program and real property holdings require significant management attention. Effective and efficient implementation of the improvements in these programs recommended in the Booz, Allen/RTKL study will add to these management responsibilities. To place these responsibilities on DM&S and the Chief Medical Director would divert attention away from the Department's primary health care mission and is not appropriate. Second, the VA's facilities program provides leasing, work space management, real property management, and planning, design and construction support to all three VA Departments and several VA staff offices. In the years ahead, I anticipate an active colocation program for DVB's regional offices, and continued expansion of our national cemeteries to meet our projected needs. These programs and their resource needs can best be supported by an independent facilities office whose primary mission is to serve the needs of all VA elements rather than to be a secondary mission of one of the VA's Departments. Finally, there is the issue of program oversight. Retention of an independent facilities office directly responsible and accountable for the sole function of meeting the capital facilities and real property needs of all elements of this Agency preserves and maintains critically needed program oversight and control of these programs more than any other organizational alternative. On the other hand, from a purely management perspective, placement of these responsibilities in one user department is inherently imbalanced and creates the need to establish new independent oversight elements in other VA organizations whose ability to accomplish such oversight effectively is problematic.

7. Based on these factors and concerns, I have concluded that the capital facilities and real property programs within the VA must be consolidated and must be preserved as an independent staff office function. Consistently with Mr. Walters' proposal of last October, I, too, am firmly convinced that the Facilities Engineering, Planning and Construction (FEPAC) Office functions in DM&S and the Office of Construction must be consolidated into one unit. Accordingly, I have decided to transfer to the Office of Construction the personnel, resources and functions of the Facility Engineering, Planning and Construction Office in DM&S with the exception of the following FEPAC functions more appropriately retained by DM&S and nine (9) FEPAC FTEE to support these functions:

- o Facility Activation Staff;
- o Occupational Safety and Health;
- o 2 FTEE in FEPAC's Facility Planning Support (ADP) staff to develop appropriate budget and ADP interfaces; and

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- o the nonstructural fire and safety functions of issuance of certificates of equivalencies to the Joint Commission on Accreditation of Hospitals (including review and approval of all consultant fire safety evaluation system (FSES) analyses, approval of plans of corrective action, final approval of completed fire and safety work, and accomplishment of the second (internal) FSES analysis); issuance of operational fire and safety procedures and guidelines for VA facilities (e.g., evacuation procedures); establishment of guidelines, standards and procedures for VA fire departments; development and conduct of all fire protection training programs for all VA facilities; and investigation of fires in VA facilities. DM&S will retain its role as the VA element responsible and having jurisdiction for directing policy for all fire protection matters on an agencywide basis similar to the role that the Designated Agency Safety and Health Official (DASHO) has for directing agencywide occupational safety and health policy and agencywide asbestos policy.

It should be noted that in addition to the nine FEPAC FTEE to be retained by DM&S, DM&S also will retain the positions and incumbents of the seven construction coordinator positions already established in DM&S regional offices. These 16 FTEE will provide the necessary staff support for DM&S interface and liaison with the Office of Construction. The distribution within DM&S of the nine FEPAC FTEE will be at the discretion of the Chief Medical Director.

8. Inasmuch as the provisions of 38 U.S.C. section 210(b)(2) do not apply to this realignment, this transfer of functions and FTEE will be effective July 31, 1986, through employee details (not to exceed 64 FTEE) from FEPAC to the Office of Construction to facilitate the transition. A budget amendment will be prepared for FY 1987 to reflect this transfer and the transfer of funding for the affected FEPAC elements from Medical Administration and Miscellaneous Operating Expenses (MAMOE) to Construction Minor (General Administration). Therefore, effective July 31, 1986, from the FY 1986 FEPAC ceiling of 78, 64 FEPAC FTEE will be detailed to the Office of Construction and effective October 1, 1986, these 64 FTEE will be permanently transferred to the Office of Construction. Nine FEPAC positions will be retained in DM&S. The remaining 5 FEPAC FTEE will not be filled in order to achieve the previously agreed upon FY 1987 ceiling of 73 for the former FEPAC elements. Effective October 1, 1986, the newly combined FEPAC and O/C offices will be renamed "Office of Facilities", to reflect more appropriately its responsibilities for overall management of an integrated facilities program, including real property and space management in addition to its project planning, design and construction activities.

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9. With respect to this decision, the following responsibilities are defined:

- The Chief Medical Director, the Chief Benefits Director, the Chief Memorial Affairs Director and Staff Office Directors will be fully responsible for establishment, definition and projection of their program needs and the prioritization of those program needs (e.g., MEDIPP). In turn, these program needs will be provided in a timely manner to the new Office of Facilities, for incorporation into agencywide facility development planning and the ultimate planning, design and construction of specific projects. DM&S will continue to be responsible for sizing models, including the VA-GAO Bedsizing Model, and will provide this data to the Office of Facilities for translation into project specific requirements.

- The Associate Deputy Administrator for Logistics will be responsible for policy level oversight of the VA's capital facilities and real property programs. The Office of Facilities will report to the ADA for Logistics.

- The Director, Office of Facilities, will be the senior VA management official fully responsible and accountable for the overall Agency capital facilities and real property programs.

- Based on DM&S medical program planning data and the program planning input of DVB (if colocation of a regional office is involved) and DMA (if a VA cemetery is involved), the Office of Facilities will be responsible for preparing and implementing facility development plans for all VA medical centers as recommended by the Booz, Allen/RTKL report. It also will be responsible for all Major, Minor, Minor Miscellaneous and Nonrecurring Maintenance (NRM) project planning, design and construction in support of all VA Department and staff office needs. In general, Minor, Minor Miscellaneous and NRM projects will continue to be delegated by the Office of Facilities to the field for accomplishment in accordance with Office of Facilities management guidelines and oversight. Selected Major projects also may be proposed for delegation to the field where

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appropriate. Also in support of all VA elements, the Office of Facilities will have prime responsibility for all leasing, work space management and real property management (e.g., land acquisitions/disposals, land utilization surveys, environmental compliance and historic preservation). Execution of these programs may be delegated by the Office of Facilities to field units as appropriate. Based on the Departments' program planning data and priorities, the Office of Facilities will establish project priorities for inclusion in nationwide construction planning documents (e.g., Five Year Medical Facility Plan), prepare those nationwide construction planning documents, develop project schedules (e.g. Advance Planning Fund and Design Fund lists), and prepare budget submissions. These documents will be approved by the affected Department head before being finalized. The Office of Facilities, similar to the Offices of Procurement and Supply and Personnel and Labor Relations role with each medical center's Supply or Personnel Services, also will provide policy guidance to the medical centers' Engineering Service, including liaison with field facility engineers, for the resolution of facility maintenance problems. Field Engineering Service personnel, like field Supply and Personnel Service personnel, will remain DM&S employees. In this capacity field engineering service personnel will receive administrative direction from the Station Director and program direction from the Office of Facilities. The selection of Chief Engineers will be accomplished in the same manner as the cooperative roles of the Offices of Procurement and Supply and Personnel and Labor Relations and DM&S in the selection of Chiefs of Supply and Personnel.

- The Director, Office of Budget and Finance (Controller), will continue to monitor the construction and leasing appropriations process and compliance with related laws, regulations and directives. The three FTEE scheduled for transfer from the Office of Construction to the Controller in FY 1987 to enhance financial oversight and accountability of the Agency's capital facilities program will be transferred with support resources to the

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Controller effective October 1, 1986. The Controller's financial oversight role in the facilities program will continue as it is presently performed with the enhancement of the additional staff. This transfer was reflected in the VA's February 5, 1986, budget submission to Congress. The Controller and his staff will have full access to all project planning, design and construction information as well as leasing and general property management information. The involvement of the Controller's staff in the initial development of facility development plans also is essential in that these plans will form the cornerstone of the Agency's construction program. Inasmuch as there will no longer be a need for an independent facilities program oversight function, the 10 FTEE proposed for transfer in FY 1987 from the Office of Construction to the ADA for Management to staff such function is hereby cancelled.

- The General Counsel will continue to review all leasing and construction-related contractual actions, all land transactions and all environmental compliance issues for legal sufficiency in the manner in which it is presently performed.

- The Director, Office of Procurement and Supply, will be responsible for providing technical acquisition and personal property management advice, including coordination of equipment and systems purchases with supporting construction projects, in the manner in which it is presently performed.

- The Director, Office of Small and Disadvantaged Business Utilization will be responsible for providing technical advice on matters relating to socio-economic program requirements in the manner in which it is presently performed.

10. The following implementation assignments are made:

- The ADA for Logistics is charged with development of an implementation plan for the Booz, Allen/RTKL study core process recommendations. I request that the ADA for Logistics provide me with periodic progress reports.

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- The Controller is charged with immediately preparing the necessary amendments to the FY 1987 budget request to effect the transfer of the resources, FTEE and functions of the affected FEPAC elements to O/C on October 1, 1986, and transmitting these amendments to the appropriate Congressional committees.

- The CMD, and the Director, Office of Construction, are charged with developing a detailed realignment and action plan for the effective organizational integration of O/C and the functions and personnel of affected FEPAC elements which is to be effected October 1, 1986. The Office of Personnel and Labor Relations will assist the affected organizations in preparing the necessary documentation to implement the interim employee details which will be effective July 31, 1986, and is available to assist DM&S and O/C's joint development of the detailed realignment and action plan. I have reviewed the December 31, 1985, organizational proposal for this merger submitted to Administrator Walters and approved by him on January 3, 1986. With the exception of the FEPAC functions listed in paragraph 7 above, more appropriately retained in DM&S, the same realignments and consolidations will result from my decision as proposed in the December 31 memorandum. I ask that the December 31 proposal be refined and updated as needed and submitted to me for review no later than August 15, 1986. This plan also should reflect the necessary space planning to physically relocate affected FEPAC staff to the Lafayette Building. If space requirements do not permit a full consolidation, the plan should reflect which organizational element(s) in the new Office of Facilities will remain in the VACO headquarters building. The plan also should include the transfer of any FEPAC equipment and software support necessary for the Office of Facilities to accomplish its work. DM&S and O/C will need to work with the Office of Program Analysis and Evaluation to ensure that the realignment package reflects the requirements of MP-1, Part I, Chapter 7.

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- The CMD and Director, Office of Construction, in coordination with the Director, Office of Personnel and Labor Relations, will propose to me procedures for the recruitment, training and selection of Chief Engineers under the new realignment. This report also should cover issues of training and recruitment for other employees in VAMCs' Engineering Services and the funding and the supervision of engineering training facilities in Little Rock and St. Louis. I ask that these draft procedures be submitted to me by August 15, 1986.

- In FY 1987, I ask that the Controller fully assess his FTEE requirements to effectively ensure financial oversight of the Agency's capital facilities, leasing, and real property programs and advise me of his FTEE needs so that these can be reflected in appropriate budget documents.

- The Director, Office of Construction, in coordination with DM&S, DVB, DMA, the Office of Information Management and Statistics, and other appropriate staff offices, will identify and develop a plan for revising existing circulars, manuals, etc., as necessary to reflect this realignment and provide this plan to me by September 1, 1986.

- I ask that the ADA for Management, through the Office of Program Analysis and Evaluation, and the Director, Office of Personnel and Labor Relations, offer full assistance to affected elements to facilitate implementation of these decisions.

11. In announcing these decisions, I wish to emphasize the critical importance that our facilities program fully support and be responsive to the needs of the client Departments, staff offices, and field facilities. The VA's capital facilities and real property holdings are Agency resources. By this realignment, the Office of Facilities is entrusted with full responsibility to support, maintain and improve these Agency assets. At the same time, it is just as important that the facility support needs of those who work in our facilities are fully met in a timely fashion in order that they can efficiently and effectively carry out their vital field services to veterans. To ensure this end, the new Office of Facilities must work fully, openly, directly and in

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partnership with field users. Mechanisms will be established and proposed to me for approval by the Office of Facilities, in coordination with the Chief Medical Director, which will ensure a cooperative and meaningful working relationship between the new Office of Facilities and DM&S field facilities, medical program planners, professional services and Regions. I specifically request that among the mechanisms included in this proposal, the Office of Facilities include an assessment of assigning an Office of Facilities health care facility planner to each DM&S regional office to assist field facilities in planning for capital facility investments. The Office of Facilities also will develop similar mechanisms to ensure a fully responsive working relationship with DVB and DMA. This report is due to me on August 15, 1986.

12. The Administrator's announcement of October 31, 1985, is withdrawn only insofar as it may conflict with these decisions. The VA's request to Congress of February 5, 1986, to waive the requirements of 38 U.S.C. section 210(b)(2) is hereby rescinded. The Administrator's decision memorandum of December 16, 1985, "Establishment of an Associate Deputy Administrator for Management - IMPLEMENTATION", is amended to the extent necessary to reflect the decisions in this memorandum.

THOMAS K. TURNAGE

JUL 25 1986

QUESTIONS AND ANSWERS ON THE CONSOLIDATION OF DM&S AND OFFICE OF CONSTRUCTION FUNCTIONS INTO AN INDEPENDENT OFFICE OF FACILITIES

1. State the number and responsibilities of the employees which will be added or moved from each affected office.

ANSWER: 64 of the 73 authorized FY 1987 FTEE ceiling for the Department of Medicine and Surgery's Facility Engineering, Planning and Construction Office (FEPAC), will be transferred to the Office of Facilities and become employees of that office. The specific responsibilities of each employee will be determined by the Director of the Office of Construction, as part of the new organizational realignment and implementation of the Booz, Allen core process recommendations to improve the planning for facilities construction in the Veterans Administration. The total FY 1987 FTEE ceiling for the Office of Facilities will be 734. (Also see question 33.)

2. Describe the changes in functions that will occur at each affected office.

ANSWER: The overall function of FEPAC and the Office of Construction will not change, in that the consolidated Office of Facilities will continue to be responsible for the same functions for which the two separate offices are currently responsible; that is, maintenance and physical plant operations at the medical centers, real property and space management, and the VA's facility planning, design and construction programs. The consolidation of the two offices into an integrated Office of Facilities, however, will eliminate duplication. In addition, as the Booz, Allen core process recommendations are implemented, form will be adjusted to reflect function.

3. State the reasons why you have determined that this realignment is appropriate and advisable in terms of the statutory missions and long-term goals of the Veterans Administration.

ANSWER: The Booz, Allen & Hamilton/RTKL Study found that the Agency's health care facility planning process which the Veterans Administration employs needed to be strengthened in several ways, and that in the long run, medical program planning and VA health care facility planning should be fully integrated through the mechanism of facility development plans. However, the Veterans Administration also is responsible for the maintenance, planning, design and construction of nonmedical facilities, and for work space management and real estate management, acquisition and disposal, maintenance, leasing and purchase of VA facilities. Therefore, in order to achieve the planning improvements as recommended by Booz, Allen, while at the same time maintain an independent Office of Facilities, whose primary mission is to serve the integrated capital facilities needs of all VA elements, I determined that the retention and enhancement of an independent staff office is the most efficient and logical organization.

4. Describe the effects that this realignment may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the VA not directly affected by the realignment).

ANSWER: I anticipate that this realignment will improve the provision of benefits and services to veterans and their dependents significantly, by improving our entire facilities planning process, streamlining our procedures, shortening project development time, improving our criteria and standards, ensuring a single source of accountability, and enhancing field facility participation.

5. State your estimate of the cost of implementing this realignment immediately, and state the long-term costs of implementing this realignment.

ANSWER: The only near term cost of implementing this realignment is the inherent and necessary one of minor relocation costs (installation of phone lines, minor renovation of office space, etc.) when personnel are reassigned from one office to another. I do not anticipate long-term costs; rather I anticipate long-term benefits and cost savings.

6. What will happen to the 10 FTEE that you have announced would be transferred from the Office of Construction to the Office of the ADA for Management for a facilities oversight function, and the 3 FTEE scheduled for transfer to the Controller to enhance fiscal oversight of the construction program?

ANSWER: Inasmuch as there will no longer be a need for an independent facilities oversight function, residing under the Office of the ADA for Management, the FTEE that initially were to be transferred from the Office of Construction to the Office of the ADA for Management will not be transferred. The three FTEE for the Controller will still be transferred effective October 1, 1986, because of the existing need for enhanced fiscal oversight. I have asked the Controller to assess this three FTEE level and ensure it is sufficient to meet the job that needs to be done.

7. How will your realignment address the loss of control that DM&S feels over influence over construction planning and delivery, and the great user dissatisfaction with products expressed by DM&S in the past?

ANSWER: As the Veterans Administration responded on October 31, 1985, to a question posed by Mr. Marty Reiss of the Senate Committee on Appropriations Staff:

> There is a consensus among all VA elements involved in the construction program that a marked improvement in communication and field participation in the entire process has been achieved during the past two years. This effort was underway before the consultant study began. The development of the new system to prioritize the selection of construction projects also is currently in use. Among other initiatives, the VA also has moved forward in the area of prototyping; has initiated a comprehensive study of the physical plant conditions of the VAMCs to improve our planning data base, has undertaken a comparison of its construction standards and specifications with the private sector; and initiated a design fund to shorten project development time. (Emphasis added.)

With regard to recent enhancements of user participation, the following initiatives also were undertaken in the last few years: VAMC participation in architect-engineer (A/E) selections; VAMC concurrence in the selection of, and participation in, evaluation of Resident Engineers; increased emphasis on the need for, and value of, cooperation and flexibility; and the formation of an ad hoc committee to make further recommendations for improvement. Therefore, we feel that we have already made great strides toward significantly enhancing the opportunities for user participation in the VA construction process. In addition, implementation of the Booz, Allen core process recommendations will facilitate and greatly accelerate the actual construction and delivery of the product to the user by shortening the initial planning process considerably. User satisfaction should be additionally enhanced by the faster delivery of the desired product.

Most significantly, however, the institution of facility development plans (FDPs) for each of our medical centers, as recommended in the Booz, Allen Study, also will involve the VAMCs to a greater extent than ever before in initial planning. The FDPs will be wholly based on DM&S' medical program needs and priorities and will be approved by the Chief Medical Director. In addition, DM&S will continue to approve all major milestones in project development, ensuring its participation and control over needs and priorities throughout the process.

8. How will this realignment affect the lack of responsiveness of the construction program to user needs?

ANSWER: This realignment will result in an integrated, consolidated capital facilities and real property program which, when combined with implementation of improvements in our processes and procedures as recommended by the Booz, Allen & Hamilton/RTKL Study, will greatly enhance planning, the involvement of the VAMCs in that planning, and, hence, responsiveness to client needs.

9. With this realignment, is there a single accountable decisionmaker in the facilities construction program below the Office of the Administrator?

ANSWER: Yes. There is a single accountable decisionmaker for facilities construction for the Veterans Administration below the Office of the Administrator: that is the Director of the Office of Facilities, whom I shall hold responsible for all aspects of capital facility planning, design and construction, as well as other aspects of facilities, including leasing and land management. At the same time, all three directors of the departments will be responsible for their program delivery; for example, the Chief Medical Director will continue to be responsible for medical program delivery and planning. The Director, Office of Facilities, will report through the Associate Deputy Administrator for Logistics who will oversee the management of the Agency's capital facilities and real property programs to ensure they achieve the maximum efficiency and effectiveness expected from this realignment.

10. How will this realignment affect the excessive delivery time for projects?

ANSWER: In time, we expect to significantly reduce the duration to plan, design and complete construction projects. This will occur primarily through enhancements in the planning process that will avoid project recycling, as well as through improvements in the quality of basic planning data. Additional time savings will be realized by eliminating duplication and streamlining our current operations.

11. Does your proposed realignment limit the duplication, overlap, and fragmentation complained of before?

ANSWER: Booz, Allen & Hamilton identified duplication, overlap and fragmentation in the health care facilities planning process, as well as in the construction management process. That duplication, overlap and fragmentation occur primarily between FEPAC in the DM&S (and to a lesser extent, the Regional Directors in the DM&S) and the Office of Construction. As far as facilities planning goes, this realignment, by combining FEPAC into the Office

of Construction, should eliminate the duplication, overlap and fragmentation. In addition, I believe and anticipate that we will be able to eliminate the duplication, overlap and fragmentation in the project management functions as well by implementing a project manager concept in which a project management office will manage a project from project plans through construction and financial completion. The project manager, however, will not begin work on a project until the planning element has completed its responsibility, thereby achieving a crisp transfer of authority and responsibility for a specific project at a defined point in development.

12. How will your realignment affect or improve oversight of the construction program?

ANSWER: The construction program, as it is currently organized, is operated primarily by the Office of Construction which plans and executes all major construction projects, with the exception of a few projects which are delegated to medical centers. The Office of Construction also assists in the planning of minor construction projects for the three departments. Minor and nonrecurring maintenance (NRM) projects, however, are managed by the Department of Medicine and Surgery. Other capital facilities related functions are split between O/C and DM&S. In the past, this has led to confusion over who is responsible for what. Under this realignment, the Office of Facilities will be fully responsible for all aspects of an integrated capital facilities program agencywide. This will greatly facilitate the Office of Facilities' ability to manage and oversee the entire program and centralizes, in one spot, responsibility for performance. In addition, there will continue to be legal and fiscal oversight of the budget of the construction program by the General Counsel and the Controller of the Veterans Administration, respectively. Additional FTEE resources will be placed in the Controller's office for fiscal oversight. The reorganization as proposed by my predecessor, Mr. Walters, would have necessitated a different process for oversight. My realignment will perpetuate and enhance the existing oversight system.

13. How will your proposed realignment be compared to Mr. Walters' proposed reorganization regarding all the improvements that he anticipated when he decided to incorporate the Office of Construction within DM&S? Specifically, address efficiency, responsiveness of planning, creating a single point of accountability, and improving user influence on the product.

ANSWER: I firmly believe that my proposed realignment will achieve the same process improvements as would Mr. Walters' proposed reorganization, in that the efficiency and responsiveness of planning will be improved, and the duplication and overlap of management responsibility for the facilities construction program will be eliminated. In addition, it will continue to improve

and maintain our recent improvements in achieving user satisfaction with the end product. At the same time, this realignment should avoid several disadvantages of the previous reorganization proposal which I think are inherent in that proposal. First, a staff office will remain which is designed to serve the entire Agency's facilities needs, independent of any one particular user. Second, the Chief Medical Director will not be distracted from his primary mission of providing medical care to the nation's veterans, because he will not additionally be responsible for the capital facilities program for his department, as well as for the Departments of Veterans Benefits and Memorial Affairs and several of the VA staff offices.

14. How will this realignment affect the budget, and appropriations requests to Congress, and specifically the construction budget as a whole?

ANSWER: This is a question where some uncertainties remain at this time. Naturally the major construction budget for the agency as a whole will continue to be funded as a separate line item by Congress, and requested as such by the Veterans Administration with the approval of OMB. The minor construction program is funded as a separate line item by Congress and will continue to be done in this manner for the foreseeable future. The budget for nonrecurring maintenance at medical centers, which is clearly a capital expenditure, has a line item in the VA medical care budget. Whether it should remain so, or be funded within the other construction accounts, is an issue which will be comprehensively assessed. As part of this assessment, we also will review the effectiveness of the current classification of projects of Major, Minor, Minor Miscellaneous and NRM.

15. What will be the responsibility, and the line of authority for the VAMC Engineering Service employees who are now employees of the DM&S, under the direction of the Engineering Service within FEPAC?

ANSWER: The VAMC Engineering Service employees (as distinguished from the resident engineers who are employees of the Office of Construction, on site for major construction projects) are the employees of the Department of Medicine and Surgery. These engineering employees are assigned to each medical center; they are responsible for the maintenance and operations of the physical plant, safety programs and maintenance of personal and real property of each medical center, and for the supervision of nonrecurring maintenance projects, minor miscellaneous projects, minor projects and major projects when they are delegated to the medical centers for execution and administration. Currently the VAMC Engineering Service employees' work performance on the job is evaluated by medical center Directors; they receive their technical direction and advice from the Central Office Engineering Service, within FEPAC in the Department of Medicine and Surgery. Although DM&S Engineering Service and FEPAC will become a part of the Office of Facilities, these facility

engineering employees will remain as medical center employees. However, their program and technical direction will be provided by the Office of Facilities, in a manner very similar to the Chiefs of Supply at medical centers, who now obtain their contracting authority, policy and technical guidance from the Office of Procurement and Supply, while organizationally reporting to and receiving administrative direction and performance appraisals by medical center Directors. The realignment does not change the current situation, except that program and technical direction will now come from the Office of Facilities rather than FEPAC.

16. How will the VAMC Engineering Service employees be responsive to hospital center Directors for day-to-day operations and maintenance of hospitals?

ANSWER: Like VAMC Supply Service employees, the VAMC Engineering Service employees will continue to be employees of the Department of Medicine and Surgery, and therefore responsive to hospital center Directors for day-to-day operations and maintenance of the hospitals. The only thing that will change will be that the responsibilities for the Engineering Service within FEPAC will be now performed by the Office of Facilities. In effect, this means that agencywide policy issues in the engineering area will be exclusively held by one office--the Office of Facilities--rather than split between the Department of Medicine and Surgery and the Office of Construction as it is now.

17. How will this affect your 1987 budget requests? 1988 budget requests?

ANSWER: As to the 1987 budget requests, we will have to modify our requests, since the current 1987 requests have reflected the transfer of the Office of Construction to the Department of Medicine and Surgery. There will be no change in the appropriations authority in line items for Major, Minor and NRM in the FY 1987 request. When our FY 1988 budget request is formulated, it will reflect this realignment.

18. How will this affect or disrupt the construction process as it is going on right now?

ANSWER: I firmly believe that the realignment should not disrupt the construction process as it is going on right now. The actual construction for major projects is the supervisory responsibility of the Office of Construction as it exists now and that will not change. Under this realignment, no change will occur to construction projects that are delegated to the medical center Director for development and construction. In fact, we believe that the construction process will, as a result of the implementation of the Booz, Allen core process recommendations, be accelerated significantly, by virtue of time savings in the initial planning processes.

19. The Booz, Allen/RTKL report said that there was fragmentation of process management functions between the Office of Construction and DM&S which has been "purposely fostered . . . to provide a check on DM&S in defining facility construction requirements and in carrying out projects to meet those requirements," and that "this structure does provide an effective check on the process" (page ES-9). However, noted Booz, Allen, the cost is "enormous" in that it results in "confusion over who is actually responsible for managing the process," and results in a "lack of clear accountability" for management control responsibilities. Will your proposed realignment perpetuate that problem?

ANSWER: Both the previous reorganization proposal and mine are designed to address specifically this concern about fragmentation of process management functions made by Booz, Allen. My realignment proposal also places accountability for the Veterans Administration capital facilities program in one person--the Director of the Office of Facilities. What will remain in the Department of Medicine and Surgery is medical program planning. Medical program planning and medical facility planning are integrated through the facility development planning process. Facility planning does not begin until medical program planning has identified the needs and priorities. Hence, the same crisp hand-off between these management functions occurs under either proposal and responds to the Booz, Allen/RTKL concern.

In addition, I do not find as persuasive the concern that placement of both oversight and technical support responsibilities in the Office of Construction results in conflicting roles within the Office of Construction, of support for the client, plus policing of the process. What the Office of Construction is "overseeing" is enforcement of the VA's standards, criteria, policy and Administrator guidance. If accomplished correctly and professionally with their technical support role, this should not result in conflict except insofar as the client requests deviations from these standards and criteria. In this latter case, our current system allows some flexibility in our design standards and criteria, and if legitimate professional differences of opinion occur, these will be elevated, as necessary, to progressively higher levels of management for resolution.

20. The Booz, Allen/RTKL report specifically did not recommend either that the Office of Construction become a part of DM&S, or that FEPAC become a part of the Office of Construction, saying that the recommendations made in the report "stop short of full integration . . . ; moving too far, too fast, may result in serious disruptions of both (health care and construction) programs, especially during a period when other reorganizations are taking place within DM&S. Full integration without necessary oversight mechanisms (now provided, in part, by O/C) could affect program integrity." Will your proposed realignment create exactly the disruptions which Booz, Allen warned of?

ANSWER: My realignment will not create the disruptions mentioned in Booz, Allen any more than the previous reorganization proposal would have done. In the first place, the reorganization of DM&S is complete now. In the second place, my examination of the construction process has led me to believe that the construction process as it is going now can only be improved by the assimilation of the facility planning function of DM&S and the Office of Construction into one facility planning service under the Office of Facilities. Finally, it is the consensus of both DM&S and the Office of Construction that a complete marrying of the two organizations one way or the other was essential to improving the facilities planning process. As noted previously by O/C and DM&S, aligning facilities planning and project planning recognizes that the best environment for facility planning is created when a single organizational element is responsible for coordination and for providing assistance to the field in the development of potential solutions for correcting facility related problems.

21. How will the MEDIPP process be now integrated into planning under your proposed realignment?

ANSWER: The MEDIPP planning process, as it currently exists, is a very useful tool for identifying needs for future medical care facilities generally. Planning those solutions, and translating those distinct needs into specific facilities will be the purpose of the facility development plans recommended in the Booz, Allen/RTKL report as part of its core process recommendations. We strongly support the Booz, Allen recommendation to formulate facility development plans for our medical centers. This approach will incorporate the MEDIPP requirements data and identify all possible solutions to identified needs. Indeed, the facility development plans will be based on DM&S medical program planning and priorities providing a full interface between the two processes.

22. One of four short-term problems identified by Booz, Allen was the need to improve space planning criteria; what does your realignment do to effect that?

ANSWER: The organizational realignment, in and of itself, does not directly affect the quality of our currently existing space planning criteria. However, separately, I intend as part of the implementation process for the Booz, Allen core process recommendations, to direct that we substantially improve our space planning criteria and use it as an important tool in the determination of facility needs as part of our facility development plans. Currently, our criteria are not based on well-defined medical care operating modalities, nor are there standardized medical care operating modalities for the various levels of care we provide. As such, our criteria are not well accepted by the field. In addition, in many instances, our criteria are outdated, and we need to vastly improve the immediate feedback of lessons learned through our post occupancy evaluation of completed facilities into our criteria.

23. How will this realignment affect the core process recommendations made by the Booz, Allen/RTKL Study?

ANSWER: This realignment will not directly affect the core process recommendations one way or the other; rather, separately we are moving forward to implement the core process recommendations made by Booz, Allen, because we think they are good ones and useful ones. We do believe however that this realignment will facilitate the implementation of those recommendations by eliminating the fragmentation between FEPAC and the Office of Construction that currently exists in the area of initial project planning.

24. Will DM&S continue to prepare the Five-Year Construction Needs Assessment?

ANSWER: No. The Office of Facilities will prepare the needs assessment, based ultimately on the facility development plans for each medical center, as a summary of the medical care planning requirements and priorities tied to the MEDIPP process and provided to them by DM&S. The document, however, will be fully coordinated with DM&S and approved by the Chief Medical Director before it is finalized.

25. What will be the approval and funding process for a medical center to change a project?

ANSWER: With the new facility development plan process in place and ample opportunity to participate in specific project development through the Advance Planning Fund (APF) process and working drawing design, it is hoped that the need for changes after a project is in a budget will be dramatically reduced.

Medical center requested changes during working drawings or construction, however, would continue to be submitted through the DM&S Regional Offices, for screening and appropriateness, to the Office of Facilities (O/F). The O/F, in turn, will be responsible for coordination and approvals, including the provision of additional funding.

26. What overall improvements will result from your realignment?

ANSWER: The consolidation of FEPAC and the Office of Construction will achieve several improvements. This transfer will:

- o create a unified system for the Agency's capital facilities and real property programs with a single focus of management authority, responsibility and accountability;
- o create opportunities for elimination and/or reduction in overlapping authorities, duplication, fragmentation and redundancies in the existing organizational structure and processes and produce potential for achieving greater economies;
- o enable users (medical center Directors and other line and program officials) to more actively participate in the health care facility planning and construction process by providing a direct interface and through the facility development plan process;
- o assure the level of support required by the facility programs of the three VA departments (Department of Medicine and Surgery, Department of Veterans Benefits and Department of Memorial Affairs) and staff offices; and most importantly,
- o ensure that the facilities in the field are appropriately planned, designed and constructed to enhance the care and service provided to the nation's veterans consistent with the economical use of resources.

In point of fact, these are the same improvements which would be achieved under any organizational alignment which integrates the Agency's capital facilities programs in one organizational element.

27. How will the chain of command work under your realignment?

ANSWER: The realignment places the Director of the Office of Facilities as the single point of accountability for the total VA capital facilities and real property programs, reporting to the ADA for Logistics, who has responsibility for policy level oversight of the Office of Facilities. The responsibilities of the Director, Office of Facilities, begin when the Departments conclude their assessment of nationwide program needs and the priority of those needs.

28. Was your consolidation of FEPAC and the Office of Construction into an independent Office of Facilities previously considered by Administrator Walters?

ANSWER: Five organizational options were considered by Administrator Walters. The Booz, Allen/RTKL Study identified three options, based on their study of the health care facilities construction process (the study did not address the construction programs of DVB or DMA):

Option 1: Consolidate planning activities in DM&S. Controlling activities remain split between DM&S and the Office of Construction.

Option 2: Consolidate planning activities in DM&S. Consolidate control activities in the Office of Construction.

Option 3: Consolidate both planning and control in DM&S. The Office of Construction provides architectural/engineering support and design and construction services.

In viewing the consultant options, the Veterans Administration identified two additional alternatives. These alternatives were predicated on the belief that the opportunity exists to move further toward the ultimate goal recommended by Booz, Allen & Hamilton/RTKL Associates, a fully integrated Health Care Facilities planning and delivery process. These alternatives were:

Option 4: Integrate the Office of Construction and DM&S activities in DM&S.

Option 5: Consolidate all construction and facility-related activities in the Office of Construction.

The primary difference between Mr. Walters' proposed organizational response and mine is that I strongly believe the VA's facilities programs, and the oversight and control over those programs, will be better served by placing them in an independent staff office function.

29. What will be the role of DM&S in the construction process?

ANSWER: The DM&S will continue to have full and sole responsibility for defining and prioritizing their programmatic needs which require capital improvements. In addition, the Office of Facilities will continue, in general, to delegate, to the medical centers, the responsibility to execute and administer nonrecurring maintenance, minor miscellaneous and minor construction projects, as well as selected major projects. The Office of Facilities and the medical centers will work closely to translate the Department's program needs into individual facility development plans which in turn will

be reviewed and approved by the Chief Medical Director. Project specific activity will be closely coordinated with the affected medical centers. In addition, throughout the facility planning process, there will be active involvement by the DM&S Regions and the close and active interface of the Office of Facilities with the Assistant Chief Medical Director for Planning, Evaluation and Systems Development, as well as the other ACMDs.

30. The Facility Development Plan (FDP) seems to be the centerpiece of the seven core process recommendations made by Booz, Allen & Hamilton/RTKL Associates. What kind of assumptions are you making, if any, with respect to implementing the FDP?

ANSWER: The Facility Development Plans provide a strategic context within which to identify individual facility needs in priority order on a system-wide basis. These projects will become the basis of the agency's Five-Year Needs Assessment and construction budget request. Our assumptions are as follows:

- o Linkage between the MEDIPP and construction planning is in place to begin the FDP implementation stage;
- o Standards are adequate to begin the FDP implementation stage;
- o Current linkage between construction program planning and medical program planning is adequate to begin implementation;
- o An adequate budget process is currently in place to begin FDP;
- o Prioritization of construction projects will be improved based on the FDP implementation;
- o Health planners and architect-engineers will be used as consultants in the development of the FDP;
- o Planning data base will be initiated at the problem definition stage and will be continuously built upon during the FDP process;
- o Major, minor, minor miscellaneous and nonrecurring maintenance and repair construction needs will be addressed; and
- o Physical plant assessments are available.

31. Will we now see DM&S create a new staff to interface with the Office of Facilities?

ANSWER: No. There will be no need for such a staff in DM&S. The Office of Facilities will work directly with the existing DM&S medical program planners, regions, professional services and the field facilities. There is no need to create any additional organization in DM&S. Rather, what is needed is the proposed approach which will foster direct communications.

32. Will the realignment result in FTEE savings?

ANSWER: Yes. The Office of Construction's original FY 1987 FTEE request was 710. This was reduced to 660 to reflect an intra-agency transfer of 13 FTEE (10 to the ADA for Management and 3 to the Controller), a general 1 percent productivity improvement savings of 7 FTEE, and a 30 FTEE reduction as estimated by the Booz, Allen/RTKL Study in anticipation of the organizational consolidation. In addition, FEPAC's FY 1986 ceiling of 78 was reduced by 5, in FY 1987, to 73 in anticipation of consolidation efficiencies. The realignment will transfer 64 of these 73 positions to O/C, as well as transfer (i.e., retain in O/C) the 10 positions originally intended for transfer to the ADA for Management. This brings the FY 1987 ceiling for the integrated Office of Facilities to 734 as compared to 788 FTEE, which was the combined original FY 1987 O/C and FEPAC staffing request. As the above figures show, the net FTEE savings already achieved are -54 FTEE (if you base the figure on O/C's original FY 1987 FTEE request) or -28 FTEE (if you base the figures on the current combined FY 1986 ceiling of O/C (684) plus FEPAC (78)) or a base of 762. Further staffing efficiencies, if justified, will be pursued as the core process recommendations are implemented.

33. Currently the Regional Safety and Fire Protection Engineers (RSFPE) report to DM&S Regional Directors. What will be the organizational structure and role of the Regional Safety and Fire Protection Engineers when the realignment takes place?

ANSWER: The Regional Safety and Fire Protection Engineers will continue to report to Regional Directors within DM&S. Their current responsibility is to perform fire, safety and occupational health related duties, such as industrial hygiene, the Joint Commission on Accreditation of Hospitals (JCAH) and OSHA compliance, site inspections and review of construction project submissions, drawings and specifications. They will continue to do so under this proposed realignment.

Currently, the RSFPEs receive Central Office policy guidance concerning occupational health and safety related issues (primarily, guidance on implementation of OSHA regulations) from the Designated Agency Safety and Health Officer (DASHO), who is responsible to advise on implementation of these regulations agencywide. The DASHO is an independent function presently located within DM&S. Under the realignment, that function will remain where it is, and the agencywide responsibilities will not change. Insofar as the RSFPEs are responsible for occupational health and safety implementation

within their regions, they will continue to report to the Regional Directors and continue to receive their Central Office policy guidance from the DASHO.

With regard to Agency fire and safety functions, to preserve the critical need for an independent check and balance in the Agency's fire and safety program, DM&S also will continue to retain agencywide responsibility for directing policy for all fire protection matters VA-wide. In addition to its policy setting role (which includes approval of the Office of Facilities' fire and safety construction specifications), DM&S will retain the nonstructural fire and safety functions of issuance of certificates of equivalencies to JCAH (including review and approval of all consultant fire safety evaluation system (FSES) analyses, approval of plans of corrective action, final approval of completed fire and safety work, and accomplishment of the second (internal) FSES analyses); issuance of operational fire and safety procedures for VA facilities (e.g., evacuation procedures); establishment of guidelines, standards and procedures for VA fire departments; development and conduct of all fire protection training programs VA-wide; and investigation of fires in VA facilities.

The Office of Facilities, on the other hand, will be responsible for developing guidelines and procedures and policy (with the approval of DM&S) for all structural fire and safety matters, including development of maintenance oriented fire protection standards, development of maintenance, testing and inspection standards for fire protection equipment, and development of installation specifications.

In no other respect will any reorganization of the fire and safety personnel be made. The fire and safety personnel on the staff of the station Engineers at the medical centers will continue to report to those Engineering Officers who will report operationally to the medical center Directors and, through them, to the districts and regions.

34. Why not just retain FEPAC's Central Office Engineering Service in DM&S? Is this not more an operational than a construction responsibility?

ANSWER: To respond to this question, one needs to recognize the difference between a construction program and an integrated capital facilities program. The previous realignment proposal to combine O/C and FEPAC in an Office of Facilities in DM&S recognized the need to have Engineering Service in that office to ensure a fully integrated capital facilities program. The current realignment to have an independent Office of Facilities is and should be no different in ensuring achievement of that goal.

Field Engineering Officers will continue to be DM&S employees, similar to Supply Officers at each medical center. As such, recurring maintenance problems and day-to-day operational needs will be addressed as they always have been and performed by the Engineering Officers with general policy guidance by the Office of Facilities. The purpose of transferring the Central Office Engineering Service staff to the Office of Facilities is to provide a totally integrated facilities program which includes the Major, Minor, Minor

Miscellaneous and NRM programs. The role of the Office of Facilities will be to ensure this coordinated, integrated facilities program through policy guidance, technical direction and support, and advice to field engineering personnel. The role of medical center Directors is to provide supervision and administrative direction to the field Engineering Officers. Currently, the construction programs are fragmented from the rest of the NRM program. This results in coordination problems. It should be noted that the annual nonrecurring maintenance budget is huge--in FY 1984, the NRM program encompassed 78.2 percent of the health care facilities construction workload and accounted for 21.7 percent of the Agency's capital improvements dollars. With policy and guidance for Engineering Officers in the field coordinated with all other facility matters in the Office of Facilities, the nonrecurring maintenance program will be fully coordinated and integrated with all other capital improvements projects at the medical centers, districts and on a national level. At the same time, the Engineering Officers at each medical center will be directly responsive to the medical center Directors from whom they receive administrative direction. In short, the medical center Director retains the administrative control over the onsite operations and maintenance, with the Office of Facilities having program oversight and direction. Essentially, this means that the medical center Director will continue telling the onsite operations and maintenance officers WHAT has to be done, while the Office of Facilities tells those offices HOW to do it and ensures that the resources are available.

In addition, the distinction between operations and capital facilities concerns must be clearly made. Operational organizations within DM&S and at each medical center are concerned with delivery of medical care. Coordination of Minor, Minor Miscellaneous, nonrecurring maintenance and repair, and delegated Majors, biomedical engineering, maintenance and operation of the physical plant and structural safety and fire protection are capital facilities concerns.

The integrated facilities program now proposed eliminates institutional barriers which existed when FEPAC's Engineering Service was separated from O/C and places the vast technical and programming resources of O/C (O/F) directly at the disposal of, and in an operational responsibility to, the facility operations arm of the medical centers. And, as noted above, it does so without bridging the medical center Director's overall responsibilities.

Finally, the concern that Engineering Service's duties are not "construction" responsibilities reflects a misunderstanding about the role of the Office of Facilities. The Office of Facilities' role is not that of a "construction" only organization, but rather manager and provider of the VA's entire capital facilities and real property programs.

35. Will not the transfer of DM&S' Central Office Engineering Service to the Office of Facilities diminish the responsiveness and flexibility of field engineers to meet day-to-day operational needs at VA medical centers?

ANSWER: As noted previously, recurring maintenance problems and day-to-day and emergent operational needs will be addressed as they always have. The non-capitalized maintenance and repair work ($79.9M budget in FY 1987 to perform work of a sustaining nature to prevent or offset the physical deterioration of real property to maintain facilities at existing levels) will still be under local control just as it is now. It should not matter if facility engineers call a Central Office Engineering Service in DM&S or in the Office of Facilities as long as they get answers and timely action. In addition, the wider technical and administrative support in the Office of Construction (Office of Facilities) should greater enhance responsiveness.

36. Why transfer DM&S' Central Office nonrecurring maintenance and repair program to the Office of Facilities?

ANSWER: The VA's capital program is funded from two sources: the Construction account (includes Major, Minor and Minor Miscellaneous projects) and the Medical Care account (which, under object class 32, contains the four elements of the nonrecurring maintenance and repair program). The definitions of these four elements (BSER, BSEA, Minor Improvements, and M&R--capitalized and non-capitalized) clearly indicate the integral role of all of these elements, including M&R (non-capitalized), with facility construction. While on the surface it might appear as if M&R (non-capitalized) could be segregated from the NRM program, M&R (non-capitalized) is an integral part of NRM projects. For instance, you could have an NRM project, a portion of which could qualify for M&R (non-capitalized) funding. There is no reasonable or responsible way to break out M&R (non-capitalized) from the overall NRM program, which in turn, is a substantial portion of the VA's overall capital facilities program.

37. Why transfer DM&S' Central Office biomedical engineering program to the Office of Facilities?

ANSWER: Biomedical engineering consists of highly trained engineers who are responsible for managing and maintaining the complex clinical equipment programs at the medical centers. They currently report organizationally to the medical center Chief Engineer and, under the realignment, would continue to do so. As with everyone in the field Engineering Service, they also would continue to be DM&S employees with administrative direction from the medical center Director and program direction from the new Office of Facilities, just as it previously was with FEPAC.

Biomedical engineers are liaisons between the clinical and administrative sides of the house at the medical centers. They are the pivot point for equipment layouts, vendor selections, integration of complex medical equipment systems, and installation and maintenance of such equipment. As such, they are actively involved in the development of construction projects. The professional input of biomedical engineers in equipment layout strengthens

the VA's acquisition planning and design, purchase and maintenance of major capital outlays by the Agency (e.g., CAT Scan, MRIs, radiology and nuclear medicine and other monitoring systems).

A case could be made for separating biomedical engineering out of Central Office's Engineering Service and making it a separate professional service in DM&S Central Office. However, again, this only fragments the goal of a fully integrated capital facilities program. When the Office of Construction was proposed for transfer to DM&S, it was determined that FEPAC's Central Office biomedical engineering staff should be retained in the DM&S' Office of Facilities to provide Central Office level biomedical engineering professional support and program development to the field biomedical engineers. This still makes sense under the independent Office of Facilities concept.

38. Who will be responsible for the VA's Art-in-Architecture Program?

ANSWER: Prior to September 20, 1984, the VA's Art-in-Architecture Program was administered by the Office of Construction. As of September 20, 1984, however, the Administrator delegated the Art-in-Architecture Program to the Department of Medicine and Surgery which, in turn, plans to delegate administration of this program to field facilities. Under the realignment, DM&S will continue to have jurisdiction over the Art-in-Architecture program.

39. Why not leave the planning component of FEPAC in DM&S? Wouldn't this ensure closer integration with MEDIPP?

ANSWER: Under the previous reorganization proposal, it was determined that the Agency would best be served by consolidating all facility planning, design and construction (and related activities) into one integrated capital facilities program. I fully agree with this previous conclusion, and my realignment reflects this concept.

The closer integration of MEDIPP with facility planning will occur in two ways: first, with better and more timely MEDIPP data that "holds" over time and, second, with the translation of that data into the Facility Development Plans. The Facility Development Plan is the interface between MEDIPP (medical program planning) and construction (facility development planning). All FDPs will be reviewed throughout their development by DM&S and are ultimately approved by the Chief Medical Director. They also will be periodically reviewed and updated, as necessary, to reflect changing medical program needs and priorities. Existing DM&S staff (Director of Operations, ACMDs, Regions, Districts and VAMCs) can perform this function without a duplicative, separate staff in DM&S. These DM&S entities would be reviewing FDPs anyway even if a FEPAC existed in DM&S.

The issue of retention of the "planning component" in DM&S reflects the possible confusion about the necessary, but distinct, roles (and different skills and talents) of program planning versus facility planning. On the one

hand, the programmatic planning of the delivery of medical care is the sole responsibility of the Chief Medical Director. This includes the allocation of resources, what medical services to provide, the level of medical services needed and where, etc. Facility planning, on the other hand, is the process of planning facilities, whether it be by purchase, lease, renovation or new construction, which will meet the stated needs of the Department's program planners. The program planners must determine their priority of deficiencies and anticipated needs which must be addressed to continue to provide their stated and approved level of medical care delivery. In other words, the Chief Medical Director has the responsibility for centralized control of that program planning and its necessary prioritization among the various medical centers' stated needs; whereas, the centralized control for facilities planning is within the Office of Facilities. If this distinction can be appropriately understood, there is no legitimate purpose for a facility planning component within DM&S, just as there is no legitimate purpose for a medical program planning component in the Office of Facilities. The medical program planning process (MEDIPP) becomes linked with (and indeed drives) the facility planning process in the development of the FDPs.

b. **Nonrecurring Maintenance and Repair Program**

(1) The NRM (Nonrecurring Maintenance and Repair) funds are included in the medical care appropriation (0.23) for nonrecurring M&R (Maintenance and Repair), nonrecurring BSER (Building Service Equipment Replacement), BSEA (Building Service Equipment Additions) and MI (Minor Improvement); therefore, each should be properly identified on each project submittal. The types of work covered in each area are:

(a) M&R

1. Replacement of complete or major segments of utility systems, which include systems within a building.

2. Replacement of complete or major segments of building components such as doors, windows, flooring, floor covering and ceilings.

3. Replacement of major items of work on a building shell, such as roofing, tuckpointing and waterproofing.

4. Replacement of patient support and fire protection systems such as nurses call; AOV (air, oxygen and vacuum) sprinkler and fire alarm systems.

5. Maintenance work on roads, grounds, structures and exterior distribution systems, provided that the area involved is not scheduled for modernization or expansion.

(b) BSER. This category of maintenance is designed for the replacement of complete units of items which qualify for replacement when they can no longer be economically maintained. Replacement equipment should be planned to provide models embodying the most up-to-date technological advances and economic factors. Necessary action will be taken to insure that the value of items replaced be removed from the asset accounts and supporting records. Cost to update or improve existing utility service to the equipment should be identified as M&R.

(c) BSEA. This category of maintenance is designed for new building service equipment acquisitions and expanded capacity of existing equipment servicing a larger area or function. Installation costs for equipment will be restricted to charges for work necessary to put the equipment in place and make proper hookup to available utilities adjacent to the equipment. Costs of installing systems and utilities to and from the equipment or area adjacent to the equipment will be identified as MI (Minor Improvement).

(d) MI. Structural changes, space utilization changes, construction of additional or new space, and the installation of additional facilities and systems are classified as minor improvements. In projects for replacement of systems which include expansion to a new area, the cost related to the expansion will be considered a minor improvement. In projects that include A/E fees, a percentage of the A/E cost based on the percentage of minor improvement cost, as compared to total NRM funding (exclusive of A/E fees), will be considered minor improvement cost. Minor improvements will be planned as appropriate to provide specialized medical service projects, functional rearrangements and such additions and modifications as necessary to provide efficient and modern facilities. A project will not be fragmented into separate projects as a means of subverting the minor improvement dollar limitation.

(2) There is no cost limitation on nonrecurring maintenance and repair work that can be accomplished in a nonrecurring maintenance project, provided that the total minor improvement portion of the project does not exceed $50,000 and the work is not scheduled for accomplishment within a minor or major construction project.

c. **Construction Programs.** A project that exceeds the cost limitaton of the Nonrecurring Maintenance and Repair Program becomes a construction project. There are two programs for construction projects (Minor Construction (includes Minor Miscellaneous) and Major Construction), with the limitation of each being based on total construction cost (including fixed equipment). The total construction cost limitation for each program is:

(1) **Minor Program:**

Minor Miscellaneous	$ 50,000 - $ 400,000
Minor Construction	400,001 - 2,000,000

(2) **Major Program:**

Over $2,000,000

d. **Purchase and Hire (P&H) Projects.** It is a general policy of the VA to accomplish projects by formal contract; however, in special cases to avoid continued interferences with normal hospital

Veterans Administration

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7. Maintenance and repair and capital investment: Increase of $72,554,000

When the Veterans Administration (VA) was formed, it obtained many of its facilities by inheritance from other agencies. Additional medical facilities were constructed after World War II. Because the VA is now comprised of many buildings over 30 years old, maintenance needs are increasing dramatically. Past funding levels in the non-recurring maintenance and repair (M&R) program have not allowed the Agency to keep pace with the effects of deterioration and modifications required because of changes in methods of patient care, advances in modern technology, code requirements, Joint Commission on Accreditation of Hospitals (JCAH) standards and energy conservation retrofit projects. An additional influence on the program level and budget is the need to maintain and upgrade building service equipment components and utility systems as part of interior and exterior maintenance projects. It is imperative that aging VA facilities be maintained at a level where accreditation and patient safety are not compromised. The following chart provides a detailed analysis of the resources requested for capital investment in 1987. A discussion of the resource change for each category follows the chart.

SUMMARY OF RESOURCE INCREASES, SECTION 7
(dollars in thousands)

Program	1986 Estimate	1987 Estimate	Increase (+) Decrease (-)
a. Object class 31 equipment:			
(1) Replacement equipment:			
Existing facilities	$ 73,446	$ 71,801	$- 1,645
Construction projects	100,000	106,504	+ 6,504
Subtotal	173,446	178,305	+ 4,859
(2) Additional equipment:			
Existing facilities	42,466	69,294	+26,828
Advanced technology medical equipment sharing	10,000	...	-10,000
Education and training	2,000	2,000	...
Other program improvements	1,300	...	- 1,300
Construction projects	68,750	56,259	-12,491
Computerized systems	14,661	38,272	+23,611
Subtotal	139,177	165,825	+26,648
Total object class 31 equipment	312,623	344,130	+31,507
b. Object class 32 lands and structures:			
(1) Replacement building service equipment	23,977	26,140	+ 2,163
(2) Additional building service equipment	13,547	15,708	+ 2,161
(3) Minor improvements	24,670	27,983	+ 3,313
(4) Maintenance and repair (Capitalized)	37,776	57,096	+19,320
Total object class 32 equipment	99,970	126,927	+26,957
c. Maintenance and repair (M&R) (Non-capitalized)	71,800	79,903	+ 8,103
Total capital investment (including facility activations)	484,393	550,960	+66,567
Less: Capital investment for facility activations (see section 8):			
Replacement	-100,000	-106,504	- 6,504
Additional	- 70,000	- 57,509	+12,491
Total object 31 facility activations	-170,000	-164,013	+ 5,987
Total capital investment this section (excludes facility activations)	$314,393	$386,947	$+72,554

7.a. Object class 31 equipment program:

Object class 31 equipment program for the Medical care appropriation activities are identified in two categories: (a) replacement; and (b) additional. Object class 31 equipment is personal property of a durable nature which normally has a useful period of service of at least one year.

(1) Replacement equipment: Replacement equipment levels are determined in accordance with prescribed equipment life expectancy tables and use standards. These criteria require that equipment items be repaired, refinished or refurbished and continued in service as long as economically feasible. The majority of medical equipment should be replaced within 5 to 10 years after being placed in use. In 1987, $178,305,000 is the estimated level for replacement equipment. Of this amount, $106,504,000 is for facility activations (see section 8) and $71,801,000 is for existing facilities. This level will allow the Agency to meet 27.7 percent of the total 1987 equipment replacement estimate. The chart below highlights replacement equipment estimates for 1986 and 1987:

(dollars in thousands)

	1986 Estimate	1987 Estimate
Prior year backlog	$298,156	$369,813
Current year estimates	+245,103	+273,193
Total	543,259	643,006
Less: planned obligations	-173,446	-178,305
Total end of year backlog	$369,813	$464,701

(2) Additional equipment: Additional equipment is new equipment at existing medical centers (equipment for new facilities is included in section 8) and is comprised of: (1) equipment for existing medical centers; (2) equipment for education and training; (3) equipment for other program improvements; and (4) equipment for computerized systems. In 1987, $165,825,000 is requested for additional equipment. Of this amount $57,509,000 is for facility activations (see section 8), with the remaining $108,316,000 to be utilized as follows:

(a) $69,294,000 will be utilized for purchasing additional equipment at existing medical centers (VAMC's). This estimate is based upon the need to equip VAMC's concurrent with the implementation of new medical and administrative technology. This funding level will provide limited improvements in the utilization of equipment at existing VAMC's involving functional areas related to the care and treatment of patients. In addition, any analysis of funding levels for replacement and additional equipment must consider the fact that although a piece of equipment may replace another piece of equipment, if the new equipment performs an additional task it is considered additional equipment. Included in this section are resources for the purchase and installation of telephone systems.

(b) Current estimates indicate the additional equipment level for education and training facilities will remain at $2,000,000 in 1987. Equipment in this category includes conference and training equipment at VA Regional Medical Education Centers (RMEC's); patient education programs; microfilm readers/printers to support shared journal acquisition programs; and continuation of the video-notebooking capability recommended by the VA Inspector General.

(c) In 1987, $38,272,000 is requested to support computerized systems equipment acquisitions. This request level is composed of a recurring base of $2,004,000 and includes $1,250,000 to support automated data processing (ADP) equipment acquisitions for facility activations (included in Section 8).

In 1986, capital accounts included $10,000,000 for advanced technology medical equipment sharing (for equipment in excess of $500,000). This pilot program was restricted to VA facilities where other non-federal sources commit to financing at least 50 percent of the acquisition costs. Also included in the 1986 capital accounts was $1,300,000 for other program improvements. In 1987, these 1986 non-recurring purchases have been reduced from the base.

7.b. Object class 32 - lands and structures:

Equipment in this section includes pieces of operating equipment permanently installed in, or attached to, buildings and structures (real property) that make the building safe and suitable for occupancy. A total of $126,927,000 is requested in 1987 as describe below:

(1) Replacement building service equipment: In 1987, $26,140,000 is requested for replacement equipment. Equipment in this category is used to replace items of like capacity and usefulness including boiler plants; electrical and air conditioning equipment; elevators; emergency power generators; pumps; water heaters; etc. This funding level will allow the Agency to meet 13.7 percent of the total 1987 replacement equipment level. The chart below provides an overview of this program:

(dollars in thousands)

	1986 Estimate	1987 Estimate
Prior year backlog.....	$ 119,477	$ 139,833
Current year estimates.....	+ 44,333	+ 51,500
Total.....	163,810	191,333
Less: Planned obligations.....	- 23,977	- 26,140
Total end of year backlog.....	$ 139,833	$ 165,193

(2) Additional building service equipment: Program levels are based on central office review of individual center requests for additional building service equipment items. Improved aseptic and housekeeping techniques require installation of additional sinks, temperature controls, and hot water generators. Increased use of electro-medical equipment requires expansion of electrical systems with manual and automatic controls as well as air conditioning and ventilation equipment, especially at older centers. The 1987 request is $15,708,000.

(3) Minor improvements: The minor improvement program provides for structural changes, additional space, new or expanded utilities, or alterations, modernizations and space utilization changes to buildings, structures or grounds where the improvement costs for each project are less than $100,000. This includes station labor when used, but excludes the cost of installed equipment. A funding level of $27,983,000 in 1987 will provide for the completion of high priority minor improvement projects. This funding level will support the installation of additional equipment and improvements needed to correct code and criteria deficiencies.

(4) Maintenance and repair (M&R) (capitalized): Capitalized M&R projects replace major segments of: interior and exterior utility systems; individual building components (windows, doors, etc.); and patient support and protection systems (sprinkler, air-oxygen, vacuum, etc.). This work adds to the value and extends the useful life of the structure. Because of the number of aging facilities, these projects in many cases are necessary to correct code and "critical operational" deficiencies. The 1987 estimated level for M&R is $57,096,000.

7.c. Maintenance and repair (non-capitalized):

Non-capitalized M&R work is of a sustaining nature to prevent or offset the physical deterioration of real property. Funding for these projects is estimated at $79,903,000 in 1987. These projects do not add to the value of the real property but are necessary to maintain facilities at existing levels.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

SEP 19 1986

Honorable Bob McEwen
House of Representatives
Washington, D.C. 20510

Dear Mr. ~~McEwen~~ Bob,

It has come to my attention that a malicious rumor spreading throughout your district alleges that the Veterans Administration is preparing to close the medical center at Chillicothe. Nothing could be further from the truth.

I have no intention or plans to close the Chillicothe VAMC. In fact, new construction and a new expanded mission change have been proposed for the facility.

I encourage anyone who hears differently to call me. I will not only tell them that Chillicothe is a fine medical center which will remain open, I will offer to them my thoughts about you--namely, that you are one of the leading veterans' advocates in the Congress.

I thank you for your loyal and selfless work for our Nation's veterans.

Warm personal regards.

Sincerely,

THOMAS K. TURNAGE
Administrator

STATEMENT OF THE HONORABLE TIMOTHY J. PENNY

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

AUGUST 7, 1986

MR. CHAIRMAN: AS YOU KNOW, I DON'T OFTEN MAKE OPENING STATEMENTS BEFORE THIS SUBCOMMITTEE. TODAY, HOWEVER, IS AN EXCEPTION FOR TWO REASONS--FIRST BECAUSE WE HAVE THE OPPORTUNITY TO QUESTION THE NEW VA ADMINISTRATOR, MR. TURNAGE, IN HIS FIRST APPEARANCE HERE AS ADMINISTRATOR, AND SECOND BECAUSE THE ISSUE OF THE VA PLANNING PROCESS IS UNDER DISCUSSION. THIS MATTER IS NOT NECESSARILY NEAR AND DEAR TO MY HEART, BUT IT IS MUCH MORE LIKE A THORN IN MY SIDE.

IT TENDS TO BE IN WASHINGTON THAT BOTH WE IN CONGRESS AND FOLKS IN THE BUREAUCRACY DON'T PLAN BEYOND THE NEXT COMMITTEE HEARING, DON'T PLAN BEYOND THE NEXT ELECTION, DON'T PLAN BEYOND THE NEXT FISCAL YEAR. WE MUST GET OUT OF THAT SHORT-SIGHTED CYCLE OR WE'RE GOING TO BE INVOLVED IN A TREMENDOUS AMOUNT OF WASTE. I HAVE OFTEN CHALLENGED THE VA ON THE USE OF BUILDING 43 AT THE MINNEAPOLIS VAMC, WHICH WILL SOON BE VACATED WHEN THE NEW HOSPITAL THERE IS COMPLETED. IN APRIL WHEN I RAISED THIS ISSUE AGAIN, NO ONE FROM THE VA COULD GIVE ME AN ANSWER AS TO JUST HOW THIS LARGE, VA-OWNED BUILDING MIGHT BE USED. THIS LACK OF FORESIGHT IS JUST ONE SMALL EXAMPLE, BUT I THINK THERE'S A PROBLEM THROUGHOUT THE VA SYSTEM.

I WOULD LIKE TO SEE SOME EVIDENCE THAT THE VA IS COMING TO GRIPS WITH THE PLANNING PROCESS. A PLANNING PROCESS BY ITSELF IS WORTHLESS IF IT JUST LEADS TO ANOTHER PLANNING PROCESS AND ANOTHER AND ANOTHER. I WAS PLEASED WITH MR. WALTERS' PROPOSAL THAT THE PLANNING-CONSTRUCTION BE CONSOLIDATED WITHIN THE DEPARTMENT OF MEDICINE AND SURGERY BECAUSE I THOUGHT THAT THIS CHANGE MIGHT GIVE US THE COORDINATION, BASED ON HEALTH CARE AND FACILITY NEEDS, THAT HAS BEEN SORELY LACKING. NOW WE'VE LEARNED THAT MR. TURNAGE

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HAS JUNKED MR. WALTERS' PLAN AND HAS DEVISED ANOTHER APPROACH. THAT'S HIS PREROGATIVE AS ADMINISTRATOR. BUT I INTEND TO EXERCISE MY PREROGATIVE TODAY IN RAISING SOME QUESTIONS WITH MR. TURNAGE ABOUT HIS PROPOSAL AND FINDING OUT JUST WHERE THE PAPER CHASE STOPS AND THE SOLID ACTION BEGINS.

INTENTIONAL
BLANK

TESTIMONY BEFORE SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE, COMMITTEE ON VETERANS AFFAIRS

AUGUST 7, 1986

by

ALADINO A. GAVAZZI, LFACHA (Retired)

MR. CHAIRMAN:

I AM PLEASED TO APPEAR BEFORE YOUR SUBCOMMITTEE AND GIVE MY VIEWS AS THEY PERTAIN TO THE ANNOUNCED PLAN TO REARRANGE THE VETERANS ADMINISTRATION CONSTRUCTION AND PLANNING PROCESS.

FIRST, LET ME SAY THAT ANY REORGANIZATION WILL SUCCEED OR FAIL DEPENDING ON THE PLAYERS ASSIGNED TO THE NEW ORGANIZATION. PUTTING SQUARE PEGS IN ROUND HOLES WILL ONLY RESULT IN FAILURE. IT SEEMS TO ME THAT EVERY ONCE IN A WHILE PEOPLE TRY TO REINVENT THE WHEEL.

I FIRST GOT INVOLVED IN THE HOSPITAL CONSTRUCTION PROCESS WHEN WE OPENED THE BROOKLYN VA HOSPITAL IN 1950. A BEAUTIFUL STRUCTURE WITH MANY FUNCTIONAL FLAWS THAT TOOK MANY YEARS TO CORRECT. IN 1953, MANHATTAN VA HOSPITAL--SAME STORY. PROBLEM APPEARED TO BE THAT PEOPLE WHO NEVER WORKED IN HOSPITALS PLANNED, DESIGNED AND BUILT THESE FACILITIES WITH VERY LITTLE IF ANY INPUT FROM THE CHIEF MEDICAL DIRECTOR OR THE PEOPLE WHO WERE GOING TO OPERATE THE FACILITIES.

IN EARLY 1963 I WAS ORDERED TO CENTRAL OFFICE FROM THE POSITION OF ASSISTANT HOSPITAL DIRECTOR TO BE THE ASSOCIATE DIRECTOR OF THE MEDICAL FACILITIES REQUIREMENT SERVICE. THIS SERVICE WAS HEADED BY A PHYSICIAN WHO HAD THE TITLE OF DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR PLANS AND COORDINATION, WHO REPORTED TO

ANOTHER PHYSICIAN WHO WAS THE ACMD AND REPORTED TO THE CHIEF MEDICAL DIRECTOR. I WAS DIRECTED BY THE CHIEF MEDICAL DIRECTOR TO BRING IN PEOPLE WITH FIELD EXPERIENCE AND HAVE THE OPERATING OFFICIALS IN THE FIELD REVIEW THE PLANS AND ASSURE HIM (THE CMD) THAT THEY CONCURRED WITH THE PRELIMINARY PLANS BEFORE HE, THE CMD, WOULD SEND THE PROJECT OVER TO THE ASSISTANT ADMINISTRATOR FOR CONSTRUCTION. THE SERVICE HAD 48 EMPLOYEES WHEN I REPORTED TO MY NEW ASSIGNMENT.

THIS SERVICE CONTINUED UNTIL JULY 1, 1964, WHEN IT WAS RENAMED HOSPITAL CONSTRUCTION SERVICE. WITH A PHYSICIAN DIRECTOR REPORTING TO THE CHIEF MEDICAL DIRECTOR, I CONTINUED AS HIS ASSOCIATE UNTIL JANUARY 1965 WHEN I WAS APPOINTED MEDICAL CENTER DIRECTOR, OR MANAGER AS IT WAS THEN CALLED, AT MARTINSBURG, W. VA. I MIGHT ADD THAT IN SEPTEMBER 1964, THE ENTIRE SERVICE WAS GIVEN A PRESIDENTIAL CITATION, RECOMMENDED BY DR. JOE MCNINCH, CMD, AND ADMINISTRATOR WILLIAM DRIVER AND SIGNED BY LYNDON JOHNSON, PRESIDENT OF THE UNITED STATES. INCIDENTALLY DURING THIS PERIOD WE CLOSED 15 VA HOSPITALS, AN EXPERIENCE I SHALL NEVER FORGET. I DO NOT RECOMMEND TRYING THAT AGAIN AS IT PROVED THEN TO BE POLITICAL SUICIDE FOR MANY AND WOULD BE EVEN MORE DANGEROUS TO TRY TODAY.

HAVING OBSERVED THE DIFFERENT APPROACHES BACK AND FORTH SINCE 1950, AS IT PERTAINS TO HEALTH CARE FACILITIES AND MOST IMPORTANT, CARING FOR THE VETERAN PATIENT, THE CHIEF MEDICAL DIRECTOR WOULD BE IN AN IMPOSSIBLE SITUATION WITHOUT ENGINEERING SERVICE WHO MUST REPOND TO THE MEDICAL CENTER DIRECTORS' OPERATIONAL NEEDS ON A DAILY BASIS. THE CHIEF MEDICAL DIRECTOR MUST RESPOND QUICKLY TO THE NEEDS OF THE MEDICAL CENTER WHENEVER AN OPERATIONAL NEED ARISES THAT AFFECTS IMMEDIATE PATIENT CARE. THE CMD CANNOT WAIT FOR A RECOMMENDED APPROVAL FROM THE ASSISTANT ADMINISTRATION FOR CONSTRUCTION WHICH CAN TAKE DAYS OR WEEKS. FOR EXAMPLE, NONRECURRING MAINTENANCE AND REPAIR PROJECTS WHICH MAY COST $1,000,000 MAY APPEAR AS A LOW PRIORITY TO THE ASSISTANT ADMINISTRATION FOR CONSTRUCTION AND

HIS STAFF WHEREAS IT IS CRUCIAL TO THE MEDICAL CENTER DIRECTOR WHO MAY HAVE TO SHUT DOWN THE OPERATION ROOM FOR WEEKS OR MONTHS UNLESS IMMEDIATE ACTION IS TAKEN. THIS CAN BE CARRIED OVER TO X-RAY, LABORATORY, SURGICAL AND MEDICAL INTENSIVE CARE UNITS, ETC.

A PREVIOUS ADMINISTRATOR, UPON THE RECOMMENDATION OF HIS IMMEDIATE STAFF, CROSSED OUT AN $18,000 ITEM FROM A CONSTRUCTION PROJECT WHEN I WAS THE MEDICAL CENTER DIRECTOR BECAUSE IT WAS SHOWN AS "STAGE, ROTATING" WITH A PARAGRAPH EXPLAINING THAT IT WAS PRIMARILY USED AS AN EDUCATIONAL TOOL, PERMITTING THE SETTING UP OF DIFFERENT TEACHING MODELS SO THAT THE INSTRUCTOR WOULD CONTINUETHE CLASS WITHOUT DISRUPTION BY SIMPLY ROTATING THE STAGE. A YEAR AND SOME MONTHS LATER, IT WAS BUILT AT TWICE THE COST. THE DECISION, I AM TOLD, WAS MADE WITHOUT ANY IMPUT FROM THE CMD. IT ISN"T THAT THE OFFICE OF CONSTRUCTION IS NOT COOPERATIVE, THEY JUST HAVE TOO MAY PRESSURES ON THE MULTI-MILLION DOLAR PROJECTS TO RESPOND TO THE MEDICAL CENTERS SMALL, SO IT SEEMS TO THEM, PATIENT CARE NEEDS PROJECTS. ONE NEED ALSO LOOK AT HOW LONG IT TAKES TO ACCOMPLISH COMPLETION ITEMS OF MAJOR CONSTRUCTION PEOJECTS TO GET AN IDEA ON RESPONSIVENESS.

IN MY VIEWS, IT WOULD BE IMPOSSIBLE TO HAVE AN EFFECTIVE INTERPRETATION OF PROGRAMS AND CONSTRUCTION PLANNING AT THE MEDICAL CENTER LEVEL WHEN THE RESPONSIBILITY FOR BASIC PLANNING FUNCTIONS ARE DIVIDED BETWEEN THE OFFICE OF CONSTRUCTION AND THE OFFICE OF THE CHIEF MEDICAL DIRECTOR (DM&S).

I AM REMINDED OF THE STORY TOLD TO ME BY A GERMAN POW, WORKING IN A MESS HALL AT CAMP MILES STANDISH IN MASSACHUSETTS, LATE IN WORLD WAR II. HE WAS TRYING TO IMPRESS ME WITH THE DISCIPLINE OF THE GERMAN SOLDIERS, KNOWING THAT WE HAD JUST GET BACK FROM GERMANY. HIS STORY GOES SOMETHING LIKE THIS--FIVE S.S. RECRUITS UNDERGOING LIFE SAVING INSTRUCTION AT A SPA IN AUSTRIA WERE STANDING

AT THE EDGE OF A LARGE OLYMPIC SIZE SWIMMING POOL AND OBSERVING A MAN GOING DOWN FOR THE THIRD TIME. THEY WERE ASKED BY A BYSTANDER--"WHY DON'T YOU DIVE IN AND SAVE HIM?" "WE CAN'T," ANSWERED ONE "UNLESS THE SERGEANT COMES BACK WITH THE APPROVAL OF THE LIEUTENANT."

I AM AFRAID IN THIS REORGANIZATION WE ARE LOSING SIGHT OF WHY DM&S EXISTS--TO TAKE CARE OF THE MEDICAL NEEDS OF OUR VETERAN PATIENTS. IN MY OPINION, WE ARE NOT ONLY REINVENTING THE WHEEL, WE ARE MAKING A ROUND TIRE SQUARE.

THANK YOU, MR. CHAIRMAN.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA CONSTRUCTION ACTIVITIES REORGANIZATION

WASHINGTON, D. C. AUGUST 7, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the announced plan to reorganize the VA constuction planning and management processess. The VFW is appreciative of the Chairman for holding this hearing and for soliciting our testimony so we may contribute in planning and providing for the current and future health care needs of our nation's veterans.

The Veterans Administration's Department of Medicine and Surgery's most fundamental concern must be the provision of first rate health care to this Nation's veterans. Thus, its primary involvement must be directly related to health care. However, in order to provide veterans with this "top notch" care, the Department of Medicine and Surgery must have a modern physical plant capable of fully accommodating modern innovations and technology.

This brings us to focus on the proposal to reorganize the VA's construction planning process and organizational structure. An earlier consolidation plan offered by former VA Administrator Harry N. Walters encompassed transferring the Office of Construction (OC) to the Department of Medicine and Surgery resulting in the Chief Medical Director (CMD) having full accountability and responsibility for the agency's construction program. A new Office of Facility was to have been created by combining the existing resources, staff, and functions of the Office of Construction and DM&S's Facility Engineering, Planning and Construction Office (FEPAC).

At a hearing before the Senate Veterans' Affairs Committee the VFW stated that if properly conducted, bringing VA health care facility construction under the direct control of the Chief Medical Director would provide for a more effective use of resources in delivering health care services and, thereby, increase overall VA effectiveness. While effective management of staff resources may be viewed as being very critical, effective management of facilities, equipment and supplies, is certainly of equal importance to the proper delivery of health care services to veterans. As is pointed out in the Booze, Allen & Hamilton study on the VA's method of constructing health care facilities, highly integrated efforts between health care program management and health care resources are required for the VA to effectively accomplish its mission.

For this reason, we support and continue to support bringing the VA construction program directly under the Chief Medical Director's control. We are especially concerned that a proper balance be struck between program planning and facility planning, and this is why we believe it to be of critical importance that the CMD have primary responsibility for construction activities.

We supported and continue to support bringing the VA construction program directly under the Chief Medical Director's control. VA Administrator Thomas K. Turnage has now cancelled the planned consolidation of agency construction activities in the Department of Medicine and Surgery and elected instead to create a separate, independent "Office of Facility" that will report to him through the Associate Deputy Administrator for logistics. This new office will be comprised out of what is now the Facility Engineering, Planning and Construction (FEPAC) office, which is now under DM&S and the Office of Construction. Only nine full time FEPAC employees would remain under the Chief Medical Director.

The primary driving force behind this reorganization plan, and former Administrator Walters' proposal, is the need to establish clearly defined accountability. The Veterans of Foreign Wars concurs with the finding of the Booze/Allen study that the VA construction program involves divided and redundant responsibilities and nebulous accountability. This is why we offer our basic support of the Walter's proposal and quite agree with the apparent intent behind Administrator Turnages' plan--except that we feel this new proposal would vest the organizational and oversight responsibility in the wrong hands.

The VFW feels that it would be far more effective and efficient for the determination of the medical needs along with the concomitant construction plans and actions to be consolidated under the Chief Medical Director. The CMD should have clear cut responsibility and accountability for the program since, in this way, he may continue to advocate for medical care needs and make sure that these considerations are taken wholly into account for construction planning.

We believe it to be quite evident that there is now a problem with construction interests and priorities often having a disproportionate influence on medical programs mix and direction. Even so, DM&S has endeavored over the past five years to coordinate and integrate program planning (MEDIPP) and facility planning at the District and Central Office levels. We believe that consolidating FEPAC and OC into the new Office of Facility and separating it from DM&S would damage what ever progress has been made. We also feel that under such a plan construction interest may overwhelm medical program planning.

Another concern is that moving engineering services out from under the CMD will severly impair the day-to-day operation of VA medical centers. Engineering services clearly involves key operational functions in every medical center. It is imperative that operational services be responsive to VAMC management needs. The VFW fears that this critical responsiveness would be undermined by the splitting of accountability between the new Office of Facility and DM&S. A medical center director would, for one, only have administrative control but not program control of the field station engineering service.

Mr. Chairman, we concur with Administrator Turnage that there is a need for a single organizational element within the VA which is fully responsible and accountable for the management of the agencies capital facilities and real property programs; however, we quite disagree that this consolidated authority should be taken away from the CMD and established as a independent entity. It is a well known phenomenon that organizations tend to take on a life of their own. It is our concern that an independent Office of Facility would eventually develop separate goals and priorities which could well be at odds

with those of the VA Health Care System. This health care system's primary mission--delivering top notch health care to veterans--must never be undermined.

In closing, Mr. Chairman, permit me to take this opportunity to express the appreciation of the Veterans of Foreign Wars of the United States to this Subcommittee and the House Veterans' Affairs Committee for having over the years demonstrated genuine compassion and consideration for our nation's veterans and, also, to their understanding of our concerns and recommendations.

Mr. Chairman, this concludes my testimony. I will be happy to answer any question you may have.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

FRANK DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

CONCERNING

VA MEDICAL FACILITY CONSTRUCTION ISSUES

AUGUST 7, 1986

Mr. Chairman and Members of the Committee, I am Frank DeGeorge, Associate Legislative Director, Paralyzed Veterans of America, and I am accompanied here today by Mr. Kim Beasley, Associate National Service Director, Paralyzed Veterans of America.

I would like to thank you and Members of this Committee for holding this most important hearing concerning the VA Construction Program which is so critical to the well-being of our members and our nation's veterans who have experienced spinal cord injury or dysfunction. It is on behalf of these veterans who have daily contact with the VA's medical facilities, located

throughout the United States, that we present our views and concerns here today.

The proposed reorganization of the Veterans Administration's construction management and planning process is principally driven by the findings of the Booz-Allen & Hamilton/RTKL (BAH/RTKL) Comprehensive Study completed in April, 1985. According to the Study, the VA's facility planning activities in both DM&S and Office of Construction are seriously flawed. The Study reveals the following:

a. Initial description of project scope developed by VAMCs do not provide an adequate basis for undertaking program and project planning activities. (Emphasis added)

b. The current approach to prioritizing construction projects does not provide and adequate basis for resource allocation decisions. (Emphasis added)

c. There is no clearly delineated national strategy or plan for meeting the combined construction needs of 172 VAMCs.

It is apparent, based on the findings of the Study, that the VA's annual Five Year Medical Facility Construction Needs Assessment is not an assessment of need but, rather, an executive summary of major construction projects requested by 172 individual medical centers through their Five Year Facility Plans. These Five Year Facility Plans, often referred to as "wish lists,"

are neither accurate nor are they the product of a comprehensive planning process that would ensure viability, timeliness or reasonable cost estimates.

The current transition between medical program planning and facility planning is extremely weak. The nature of the Five Year Plan, which each VAMC is asked to produce, requires gross assumptions concerning physical solutions to poorly defined problems. The VAMCs currently do not have the capability nor the resources required to do the comprehensive facility planning necessary to provide a sound basis for their construction programs. The absence of a logical system of well-defined activities for facility planning and project development allows excessive fiscal pressures to dominate the process.

If individual Five Year Facility Construction Plans are as fundamentally flawed as the BAH/RTKL Study indicates, then the VA's annual construction authorization requests have little or no basis. The VA's new Prioritization Methodology simply prioritizes construction requests, not overall construction needs. The BAH/RTKL Study states that, with the exception of projects required to support new programs identified in MEDIPP, little useful information is available for selecting projects and for justifying those decisions. As a result, trade-offs in resource allocation among VAMCs and among different types of projects at any one VAMC are often based on highly subjective evaluations where the greatest need exists.

The susceptibility of these evaluations to factors other than need, make planning procedures inefficient and ineffective in allocating resources in the best way possible. Information that objectively identifies overall

facility construction needs is of critical importance in improving construction program planning procedures.

The VA's new Prioritization Methodology was developed in response to the directive contained in Senate Report No. 98-506, which accompanied Public Law 98-371. If the intent of this directive was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first, then PVA contends that the new Prioritization Methodology fails to fulfill that intent. No mechanism currently exists whereby relative comparison can be established. Furthermore, Public Law 96-222, Section 5007, requires that the VA, each year, submit a listing, in priority order, of the medical centers it finds are most in need of construction replacement or major modernization. This listing is otherwise referred to as the "list of ten." In response to this Public Law, the VA developed its first Five Year Medical Facility Construction Plan in August, 1979. Now that the BAH/RTKL Study has identified the inadequacies of this planning methodology, this Public Law is also unfulfilled.

The findings of the BAH/RTKL Study begs the question, "How does an agency's facility planning program become so flawed?" Facility planning is accomplished primarily by architectural firms in today's building design and construction industry. It cannot be assumed that current Health Care Facility Specialists in DM&S and Office of Construction are trained facility planners capable of performing in this new role. Within these two organizational elements, FEPAC and Health Care Facilities Service, there is a noticeable absence of architects and facility planning professionals. This is an instance where a clear understanding of the process task is a

prerequisite to assigning appropriate personnel. The VA simply has not kept abreast of current facility planning techniques nor the professional expertise necessary to perform the task.

PVA recognizes that these are strong criticisms regarding the VA's current facility planning program. Nevertheless, in light of current budgetary pressures to adopt efficient operational practices, the BAH/RTKL Study, upon which these criticisms are based, is timely. The VA needs to address these serious inadequacies so that the expenditure of scarce resources can efficiently and effectively correct construction needs.

The Administrator of Veterans' Affairs, in a letter to the Executive Director of PVA, July 25, 1986, conveyed his plan to withdraw former Administrator Walters' proposal regarding the construction program. In PVA's view, the withdrawal of the first proposal does not constitute a radical policy change in the second. In fact, the similarities far outweigh the differences. Specifically, both agree with the basic findings of the Study. Both agree that it would be advantageous to designate a single source of accountability for the agency's construction program. Both agree that the implementation of the process changes will result in the best means to make major improvements in the timely and efficient delivery of health care construction. The major difference is the organizational alignment of a consolidated facility planning and construction program. PVA supports General Turnage's decision to create an independent staff office for facility planning and construction. Establishing a single source of accountability will facilitate the ability of the Administrator of Veterans' Affairs to implement the Core Process

Recommendations. However, this organizational change alone will not ensure achievement of the critical process improvements.

The implementation of the Core Process Recommendations deserve careful scrutiny because those organizational components who have allowed the process to become so flawed, have now been given the task of critiquing, interpreting and implementing those same recommendations. PVA wants to see not only timely implementation, but proper implementation.

The proposed reorganization currently being considered fails to acknowledge the impact of the Core Process Recommendations. The BAH/RTKL Study recommendations are two part: 1) Process Recommendations and; 2) Organizational Recommendations. It is not coincidental that Core Process Recommendations precede Organizational Recommendations. There is an inherent danger in implementing a detailed reorganization plan around a seriously flawed process. The Core Process Recommendations, which correct the serious procedural flaws, should be the basis of the proposed reorganization.

General Turnage states in his decision package that noticeable improvements have taken place in the construction program in the last two years. Among the improvements cited are: 1) Prioritization Methodology and; 2) Building Prototypes. PVA has already testified as to the inadequacies of the new Prioritization Methodology. The agency's recent attempts at building prototypes have been a failure as evidenced by the Nursing Home Care Prototype. This notable initiative, which began in April, 1983, sought to provide a prototypical building design resulting in quality, timely, cost effective facilities to meet the long term needs of our aging veterans. PVA

believes that this initiative was significant, viable and necessary in view of this nation's economic climate and scarce resources. However, three years later, the VA Inspector General, in a report dated January 3, 1986, states that, "The VA has not yet accomplished its major program initiative of developing a nursing home care prototype ..." The report's conclusion stated that, in the opinion of DM&S and O/C representatives, "The planned reorganization of O/C and DM&S will correct organizational issues leading to problems surfaced in this review." The Inspector General, however, stated that, "In our opinion, the planned reorganization of O/C and DM&S will not ensure the resolution of the issues related to the NHCU prototype." The Inspector General's recommendation was this, "The VA should establish an appropriate design and approval process for assuring a cost effective design of prototype nursing homes." (Emphasis added)

It is our concern that too much emphasis is being placed on organizational structure and not enough emphasis given to crucial process changes, both in DM&S and the Office of Construction.

The seven process recommendations presented in the BAH/RTKL Study represent a comprehensive approach to improving current policies and procedures in the health care facility construction process. The first recommendation begins by addressing individual medical facility needs in a systematic way, using common tools and data bases which yield comparative analyses necessary for effective resource allocation. The recommendations that follow build upon one another and strengthen the total process.

It is imperative, therefore, that the proper implementation of these Core Process Recommendations be assured. Given the interrelated nature of these recommendations, failing to properly implement the first one will have a cumulative affect on the remaining six. It is our understanding that the VA has targeted five million dollars per year for the development of Facility Development Plans (FDP) which is, in fact, the first Core Process Recommendation. The BAH/RTKL Study indicates that the development of FDPs would require some preliminary work. Specifically, this initiative would require the development of:

1. FDP guidelines to ensure consistency.

2. Computer system data requirements and programs.

To avoid costly errors in the development of this significant initiative, it is imperative that this preliminary work be completed. Our concern is that the preliminary work may not have been done. The VA's current implementation efforts indicate that the FDPs will be developed simultaneously with a planning data base. This is inconsistent with the BAH/RTKL Study. The successful implementation of this recommendation is crucial because of its use for resource allocation and decision modeling on national, regional district and local levels.

Core Process Recommendation number four also elaborates on the data base used at the national level. Data on existing facility characteristics and required facility characteristics would provide aggregate information needed for determining overall system needs. The comparative nature of the

described data base would provide a basis for broad resource allocation decisions among regions, districts or VAMCs.

Another key process recommendation focuses on the need to improve process level standards and control tools. National standards and criteria affect the planning, design cost and operation of every medical facility construction project each year. Yet, according to the BAH/RTKL Study, minimal manpower and effort is currently expended to maintain, test and update these standards. The Study indicates that the "implementation of this recommendation would require a great deal of effort not currently expended on standards development activities." This recommendation would significantly impact an organizational realignment, requiring radical changes in the development of standards and manpower needed to perform the tasks.

VA medical centers have become dissatisfied with a construction planning system that has grown less and less responsive to their needs. The process is lengthy, cumbersome and inefficient in providing capital improvements to their physical plans. They are often left out of key areas of project development. Properly implemented, the Core Process Recommendations should correct this.

Unfortunately, delegation is seen by some as a solution to these problems. Delegation is in direct conflict with the BAH/RTKL recommendations. It is a poor solution to a serious problem. By contrast, the BAH/RTKL Study conducted a comprehensive analysis which clearly defined procedural and organizational problems (see phase II of the study). An understanding of these problems became the basis for recommending a comprehensive solution.

The BAH/RTKL Study recognizes the proper role of VACO and outlines procedures for timely and appropriate field involvement.

Another key role for VACO, which is diminished by delegation, is that of a "clearing house" of valuable data and information critical to maintaining standards and criteria used in a large system of individual medical facilities. Recognizing that the VA's standards, criteria and data bases are in need of considerable improvement, which contributes to the erosion of confidence by VAMCs in VACO, the BAH/RTKL Study recommends fundamental improvements in process level standards and control tools. The tragedy of delegation lies in its lack of feedback mechanisms and control tools that are critical to maintaining agency standards, criteria and data bases. This important recommendation requires that the Office of Facilities embrace an attitude more reflective of public servants who have a responsibility to 172 medical centers, not to mention veterans, to assess their facility needs and ensure that current state of the art medical practices are accommodated.

VA facility planning, design and construction activity should be a direct response to medical program needs identified by DM&S. Removing facility planning activities from DM&S should not diminish the role of the CMD in determining medical program needs which drive the construction program. It is incumbent upon the new Office of Facilities to initiate proper procedures, as identified in the BAH/RTKL Study, that would ensure timely and appropriate involvement of DM&S in the VA's facility planning, design and construction program.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

SEP 15 1986

Honorable Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the responses to the questions you submitted following the Subcommittee's hearing on August 7, 1986, concerning construction activities reorganization.

I appreciate the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Deputy Administrator For

Enclosure

QUESTIONS OF HONORABLE BOB EDGAR
CHAIRMAN, SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
FOR THE AUGUST 7, 1986 HEARING RECORD

Question 1: As we understand it, the principal reason for the decision to go ahead with the consultant study was a nearly universally held complaint that field advice and guidance, as it affected the construction program, was totally inadequate. There were many delays, cost overruns, and very costly errors which could have been avoided. The consultant's reports confirmed these beliefs, and recommended ways to resolve these problems. The key was to assign to the Chief Medical Director total responsibility for the VA's medical facilities construction program. Your decision seems to ignore many of the concerns which prompted the initial study.

A total consolidation of authority and resources to an office external to the Department of Medicine and Surgery would appear to be the exact opposite of the consultant's major recommendations; the decision of Administrator Harry Walters, and the views of the Department of Medicine and Surgery medical center directors. This subcommittee needs to know why you chose another course.

Answer: The principal reason for the Booz, Allen and Hamilton/RTKL study of the VA's organization and procedures for constructing health care facilities was to assist the VA to determine the most efficient and effective procedural structures and internal organization to support its health care facilities construction program. Prior to initiation of this consultant study, a number of initiatives had already been undertaken to improve effective communication among the various VA elements involved in, or affected by the construction process. While yet further improvements in such communications were among the many objectives of the study, this objective was not the principal reason for the study.

The Booz, Allen/RTKL study resulted in two primary findings. The first and most important finding is that the VA's current health care facility construction policies and procedures, principally in the area of program and project planning, need to be improved. Second, the VA's integration and coordination of its health care facilities construction program is hindered by the current fragmentation of responsibilities between the Department of Medicine and Surgery (DM&S) and the Office of Construction (O/C).

To fully achieve the procedural improvements recommended by the consultants and to correct the organizational problems identified, there was unanimous agreement within the Agency that health care and other (DVB, DMA, Staff Office) facility planning, design, construction and real property functions should be wholly integrated and consolidated in one organization. Administrator Walters' proposed reorganization would have established an Office of Facilities in DM&S. My realignment retains the functions as a staff office and establishes an independent Office of Facilities which will serve the entire Agency's facilities needs. The organizational structure and functions of Mr. Walters' proposed Office of Facilities and the current Office of Facilities are virtually identical. The difference lies in its organizational location. My decision memorandum of July 25, 1986 and related questions and answers detail my reasons for retaining the construction function as an independent staff office rather than placing it in one user department.

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Question 2: As we understand the proposal, all Department of Medicine and Surgery employees of the Facility Engineering, Planning and Construction office would be moved to the new Facilities Office. The Chief Medical Director would get his only chance to influence the construction process through a "facility development plan", which would be developed by an outside contractor for each VA medical center. Your new process then would seem to be a locally-determined management plan, driven by the work of the contractors and the eventual acceptance of the Chief Medical Director without any Central Office staff to assist him. Mr. Turnage, you have made many public statements as to your commitment to central management and control, and field implementation as your mainstay philosophy. This particular plan seems to be decentralized and counter to your policy. Is it? How do you expect the Chief Medical Director to evaluate these plans in Central Office if he has lost the staff to do the job?

Answer: This plan is not counter to my policy. As I detailed in earlier material, the Chief Medical Director (CMD) and his VA Central Office and Regional Staffs have a significant amount of input and influence on the facility development plans (FDP), the data which go into their development, and the construction projects which evolve from them. He is a key decision-maker through the entire medical facility acquisition process, from initial planning through activation.

The process begins with the development of MEDIPP projections by DM&S. The projections define the mission of the medical center, its projected bed level, outpatient and clinical workloads, and specialized program. The CMD provides the guidance for the development of the MEDIPP plan and concurs with the results. This information is then forwarded to the Office of Facilities (O/F) and along with a technical physical evaluation of the medical center, it serves as the basis for developing the FDP. The O/F proceeds to develop the FDP, again working with staff designated by the CMD. The completed FDP is then approved by the CMD or his designee. If appropriate, O/F utilizes an outside contractor to assist in FDP development. The FDP will be reviewed and updated periodically.

The completed FDP provides a long range plan for the medical center's construction program. It provides a basis for the development of Five Year Construction Plans, Needs Assessments, and the prioritization of construction projects. The CMD (or his designee) continues to be very much involved in the decision-making process for these activities. He has input in the project prioritization process and will concur in all major construction project milestones (e.g., APF, Design Fund).

The CMD has direct influence on the priorities and the overall direction of the construction program for VA medical facilities. The implementation of the program to fulfill DM&S determined program requirements has been assigned to the O/F.

Question 3: Your July 25th memorandum states that it is intended that the Chief Medical Director be enabled <u>through this reorganization</u> to concentrate his energies and resources on providing quality care. There seems an inherent assumption that a medical manager of over 600 headquarters specialists and 193,941 medical facilities staff cannot be an administrative manager of the people who build and maintain the medical facilities. Based on a long history, this seems to be an indefensible position and may somewhat strain credulity. Please explain to the Subcommittee your position in respect to the Chief Medical Director's role as a manager.

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Answer: The statement contained in the July 25th memorandum concerning one of the effects of the realignment--enabling the Chief Medical Director to concentrate his energies on providing quality health care--is simply a recognition of the magnitude of that task. Delivery of the highest quality care to the millions of eligible veterans of this nation is a full time responsibility and the foremost responsibility of the Chief Medical Director. The management of a facilities and construction program of over $700 million annually is also a full time job. Many talented people are employed at the VA and the realignment will allow some of these employees to devote their full attention to the agency's construction and capital facilities programs. Working together, this approach will enable the VA to efficiently and effectively serve the needs of the veteran population.

Question 4: On page nine of your July 25th decision paper, you clearly open the door to the Controller, Mr. Hoffman, to state to you his needs for additional resources--presumably FTEE and funds--to aid him in monitoring the work to be done by the new Office of Facilities. Since it seems to us that the greatest unmet need of all will be for the Chief Medical Director to try to figure out how to deal with this new challenge, why doesn't your memorandum open that same door to Dr. Ditzler? Don't you think he might need some additional resources for this new organization?

Answer: The Department of Medicine and Surgery will continue to have full and sole responsibility for defining and prioritizing its programmatic needs which require capital improvements. In turn, the Office of Facilities is a service office to DM&S to ensure those facility needs are met in a timely and effective manner. The Office of Facilities will work directly, cooperatively and in full partnership with existing DM&S medical program planners, regions, professional services and field facilities. As such, there should be no necessity to establish a separate staff within DM&S to achieve these communications.

However, inherent in any organizational change is the necessity to analyze and evaluate that change to ensure it is fulfilling its intended purposes. Should such evaluations indicate that the Chief Medical Director needs additional resources to effectively meet the Department's workload, those resource needs will be met. The reason for specifically mentioning the Controller's FTEE requirements in the July 25, 1986 decision memorandum was in response to the need identified in the Booz, Allen/RTKL study, for additional FTEE in the Controller's office to enhance fiscal oversight of the Agency's capital facilities program.

Question 5: The Department of Medicine and Surgery is known as a "medical model". The Congress is responsible for that decision. Title 38, United States Code, requires a licensed physician to manage the organization, as well as many of its components. Thus, we have a doctor, not a Mr., Smith or Jones. In the new scheme of things, who will determine the construction-related medical priorities which so critically affect the Department's future, and the future ability of the Department to meet its mission and achieve its goals? How will those priorities be reflected in the VA's construction program?

Answer: Through the Medical District Initiated Program Planning (MEDIPP) process, the need to develop specific medical programs will be identified. In each DM&S Region, program priorities will be established and the need for facility improvements identified. Development, review and approval of MEDIPP plans involve DM&S operational and program officials in both the field and Central Office. The end result of this process is the ability of the Chief Medical Director to determine medical program priorities that require construction projects. The Chief Medical Director will

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communicate medical program priorities to the Office of Facilities (O/F) for further development in Facility Development Plans. DM&S program priorities also will be fully reflected in the application of the VA's methodology for the prioritization of construction projects. Facility Development Plans, construction planning documents, Advance Planning Fund Lists, Design Fund lists, and budget submissions will be based on the Department's program planning data and priorities and will be approved by DM&S. The technical work in putting such documents together, however, will be accomplished by the Office of Facilities.

Question 6: Is it true that your reorganization plan--in addition to allowing nine specialists involved in automated data processing and fire and safety to remain under the Chief Medical Director's supervision--would permit the Chief Medical Director to maintain one staff member in his office to serve in a liaison capacity with nearly 800 people in the Office of Facilities? Is it reasonable to expect one person to make any inroads at all against the work of 800 engineers, architects and planners?

Answer: The realignment maintains (9) nine FEPAC FTEE in DM&S to support the following functions:

- o Facility Activation Staff;
- o Occupational Safety and Health;
- o 2 FTEE in FEPAC's Facility Planning Support (ADP) staff to develop appropriate budget and ADP interfaces; and,
- o nonstructural fire and safety functions.

Although the nine FTEE figure was derived from DM&S' current staffing of these functions, the distribution of these FTEE within the Department has been left to the discretion of the Chief Medical Director. Efforts are currently underway within DM&S to determine the most appropriate placement of these positions in support of the Department's facilities related responsibilities.

The organizational placement of functions and staff will be determined by the need to ensure that DM&S goals and objectives are met, that projects are appropriately prioritized, and that correct facility solutions are achieved. As the new Office of Facilities becomes operational, DM&S must ensure that:

- o full accessibility to construction data is obtained;
- o procedures are established to monitor construction activities at all levels; and,
- o points of interface with O/F are clearly defined and adhered to.

Through the creation of the Office of Facilities (O/F) mechanisms are being established to ensure a cooperative and meaningful working relationship between O/F and DM&S field facilities, medical program planners, professional services and Regions. Through these multiple and direct interfaces the DM&S will be able to fully influence the facility process as the principal Agency user.

The VA is a single agency and working together in support of this nation's veterans, I don't expect one element of the VA to work other than in full support of the others. To suggest alternatively is contrary to the spirit of teamwork and cooperation required to carry out our mission.

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Question 7: Your decision memorandum makes a number of points about the agency's capital and plant investments. The reader is influenced that there is need for a "balanced" response to departmental needs and priorities--meaning the needs of the Department of Veterans Benefits, the Department of Memorial Affairs and the Department of Medicine and Surgery. What percentage of these total capital assets is within the jurisdiction of the Chief Medical Director as opposed to the other departmental directors?

Answer: The following charts show the approximate capital asset relationship among the departments. The first chart is based on our annual appropriations. The second chart is based upon the cost. As noted on the second chart, cost is what was paid, not the replacement or current market value. In addition, much of our cemetery land is donated. So the cost is the expense of acquiring title. The lease portion of the second chart shows a different breakdown for those properties we use but do not own.

The following are estimated percentages of the relative annual construction appropriation, both major and minor, among the VA's three departments.

MAJOR	1986	1987	1988	1989
DM&S	98.8%	99.8%	96.1%	88.1%
DMA	1.2%	0.2%	1.8%	2.3%
DVB	0	0	2.1%	9.6%

MINOR	1986	1987	1988	1989
DM&S	55.4%	54.1%	59.8%	61.5%
DMA	4.4%	2.8%	5.2%	3.9%
DVB	2.0%	1.8%	2.4%	2.0%

NOTE: Percentages for the Minor Accounts do not total 100 due to some Minor Appropriations earmarked for Line Item Categories.

The following chart lists capital assets under the jurisdiction of the VA's Departments and Staff Offices. The first section (ASSETS) shows the cost of land, buildings and other improvements as shown in our records at the original date of acquisition. It should be noted that much of cemetery land is donated, and the only costs involved are for title transfer. The second section (LEASES) shows leasing costs by Department and Staff Offices estimated for Fiscal Year 1986.

ASSETS	%	COST $
Department of Medicine and Surgery*	98.5	$ 5,128,300,000
Department of Memorial Affairs	1.5	$ 75,879,000
TOTAL	100%	$ 5,204,179,000

*(DVB facilities on medical center property are not broken out separately.)

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LEASES	%	ANNUAL COST $
Department of Medicine and Surgery	37	$ 35,385,000
Department of Veterans Benefits	46	$ 44,479,000
Staff Offices	17	$ 16,486,000
TOTAL	100%	$ 96,603,000

Question 8: Despite individual Committee members' views on the wisdom or acceptability of your decision, there is one point I would like to ask you about which merits further consideration. In the "traditional" arrangement between the Office of Construction and the Department of Medicine and Surgery, there has always been in place a type of "checks and balances" where one office's particular plans or goals could be restrained and made more rational by the plans and goals of another. While this tends perhaps to cause some delay and even may raise costs a little, many people believed that the overall program profitted from that "dynamic friction".

In your new plan, I do not see it. Where is that dynamic tension and how will it be sustained?

Answer: I appreciate the support of the individual Committee members on my decision and wholeheartedly support a system of checks and balances and the dynamic tension that it can and often does produce. One of the reasons I decided to create an independent Office of Facilities was to preserve a system of checks and balances which I thought might be diminished by placing total responsibility for both program and facility planning in one organization. The proposed realignment, which reduces fragmentation and duplication, will not reduce the interaction between the program officials and facility planners which is the basis for the dynamic tension which you describe. As a matter of fact, by removing one intervening organizational layer (FEPAC), this interface will become even more direct. Throughout the process, the Office of Facilities will work closely with the existing DM&S medical program planners, regions, professional services and field facilities. Through this continuing dialogue and the improvements we will be making to our planning process, I am confident that we will plan, design, and construct facilities in a more timely manner that will achieve a higher degree of user satisfaction than we have known before.

Question 9: Your new construction reorganization plan eliminates the Engineering Service, facilities planning and program management activities within the Department of Medicine and Surgery. What will happen to the facilities activities with the Departments of Veterans Benefits and Memorial Affairs?

Answer: Your question correctly identifies a remaining area of consideration in our decision to create an independent and integrated Office of Facilities. We are in the process of reviewing these functions and resources and determining what, if any, of them should more properly be moved to the Office of Facilities. No matter what the decision may be, we remain committed to having the new Office of Facilities serve all VA facility needs in a responsive and effective manner and are building mechanisms into our process to ensure that this is accomplished.

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Question 10: Should the Congress prohibit or restrict you from implementing this organizational change, what effect would you predict that restriction would pose for the VA's engineering, maintenance and construction plans and programs as they apply to medical facilities?

Answer: In reviewing the organizational options in the Booz, Allen/RTKL study, there was unanimous agreement by VA managers that the Agency would best be served by consolidating all facility planning, design and construction into one integrated capital facilities program. Should this not occur, our objective to eliminate organizational fragmentation and redundancies would not be met.

Question 11: In your August 7, 1986 testimony, you said that you had accepted several suggestions from Department of Medicine and Surgery personnel regarding your reorganization of VA construction activities. Please list and describe those suggestions and changes made in your reorganization plan to reflect those suggestions.

Answer: The Department of Medicine and Surgery made a number of comments in response to several drafts of my decision memorandum on the establishment of an independent Office of Facilities. Specific comments which caused specific revisions in the previous drafts were

- o IM&S' request to retain safety and fire protection responsibilities; and
- o IM&S' request to have flexibility to determine the alignment of FEPAC FTEE being retained by the Department.

In addition the July 25, 1986 decision memorandum and related questions and answers were expanded, as appropriate, to clarify and respond to the Department's concern about roles and responsibilities. The Department's written comments were made available to the HVAC staff, and on July 17 and again on July 25 the committee staff was briefed on the CMD's comments in an open and candid fashion. Throughout this process, the issues at hand have been dealt with in a forthright manner.

STATEMENT OF
DONALD L. CUSTIS, M.D.
FORMER VA CHIEF MEDICAL DIRECTOR
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
AUGUST 7, 1986

While I regret my inability to appear in person, I appreciate the opportunity to provide for the Committee's consideration my written opinion of the decision to consolidate virtually all responsibility for planning, design, construction, control and maintenance of VA medical facilities under the newly named Office of Facilities.

It is regrettable that neither this VA Administrator nor his predecessor accepted any of the organizational options recommended in the excellent Booz, Allen & Hamilton, Inc./RTKL Associates, Inc. study. It would have been, in my opinion, ill advised to have transferred totally the Office of Construction into the Department of Medicine & Surgery. More grievous still would be consolidation in the opposite direction, eliminating in effect all meaningful participation of DM&S. It would create an organizational situation destined to compound the very problems Booz Allen sought to address.

As one not inexperienced in the management of individual hospitals as well as large health care delivery systems, I find entirely specious the argument that any role in the acquisition and maintenance of facilities would "divert the Chief Medical Director's attention away from the Department's primary health care mission." One imperative element in the provision of quality medical care is the adequacy of the facilities in which that care is rendered. Ultimate judgement of such adequacy must rest with the user. Glaring examples of the consequence of ignoring medical program input were the intolerable deficiencies built into the recently constructed VA hospitals in the Bronx and Salt Lake City. Prominent among the reasons which provoked the intensive review of the VA construction organization in the first place was the costly correction of such structural mistakes.

I am reluctant to engage in a rebuttal of all the specifics in the current Administrator's proposal, and yet constrained to state that under no circumstances should the engineering service be lost to DM&S. As a matter of fact I believe I could present a compelling case for the return of the supply department to DM&S. My main concern is that if veterans health care needs are to be well served, primary responsibility for the assessment of those needs and the planning for their provision remain with the Department of Medicine and Surgery. This basic premise would be guaranteed under any one of the three organizational options recommended by the Booz Allen group. Indeed their report specifically counsels against the total consolidation of construction affairs in a single department.

Finally, I would submit that the selection of just 64 FTE to be transferred from FEPAC to the Office of Facilities is a number based not so much on any consideration of appropriate program placement as it is a calculated arrangement to stay under a ten percent shift of personnel from MAMOE and thus avoid the provisions of 38 USC Section 210(b)(2). I sincerely hope that the concerned congressional committees will nonetheless take cognizance of this action and provide some much needed guidance.